MED – ICD-10 Cross Walk Team
Diagnosis code Crosswalk Process

Purpose: The steps are intended to provide general process guidelines for cross walking the ICD-9 diagnosis codes to the ICD-10 diagnosis codes.

By October 1, 2015, Iowa Medicaid must transition to the International Classifications of Diseases 10th Edition (ICD-10) code set from the current ICD-9 code set. The transition to ICD-10 will impact every system, process, and transaction that contains or uses a patient diagnosis or procedure code. Medical Services provides medical management, clinical expertise, and analysis to support the policy and business level efforts to achieve strategic implementation of ICD-10.

Identification of Roles:

Medical Coding Specialist – Maps ICD-9 to ICD-10 codes according to processes. Utilize attention to detail in analyzing, processing, and closing assigned codes/code sets. Seek assistance as needed. Monitor pending codes at least weekly and as appropriate.

Quality Improvement Facilitator (QIF) – Reviews identified aggregate code sets as processed by coders for completeness and accuracy. Monitors escalated and pending codes at least weekly and as appropriate.

Performance Standards:

Medical Coding Specialist – Maintains average personal (Internal Quality Control) IQC score of 95% or greater.
Quality Improvement Facilitator (QIF) – Completes IQC activities for team within assigned timeframes. Utilizes attention to detail in analyzing, processing, and closing escalated codes/code sets. Is a resource to the rest of the team by providing answers to questions necessary to complete assignments.

Path of Business Procedure:

Step 1: Identify the assigned code or "*aggregate code set*" or equivalent aggregation **--** *An equivalent aggregation represents a grouping of ICD-10 codes which represent a medical concept that spans multiple codes. At IME, requests for equivalent aggregations, or aggregated code sets, will come to the Cross Walk team primarily in the form of "requirements" from the larger ICD-10 Project Team or other IME Units.*

- From assigned list of codes/code sets/chapters **OR**
- Per "*requirement*"** from ICD-10 Project Group, Medical Services, or another IME Unit

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Note: If the assignment relates to a requirement, first identify the category(s) or the reason for the selected indicator(s) [often relevant to the MMIS reference file; special edits; or IME policy related to the code] which are the focus of this code set. Categories for aggregate codes sets, or requirements, will be finalized and entered into IMAG tool (ICD-10 Mapping and Grouping Tool – see Appendix for IMAG User Guide) by the Quality Improvement Facilitator (QIF) or Manager. Examples:

- *Category: Pregnancy Indicator (from "Pregnancy Indicator" report)*
- *Category: Abortion (assigned "Requirement)*
- *Categories: Chiropractic Primary; and Chiropractic I, II, and III*

The category is defined in IMAG by the manager or QIF, and the status of the category is updated as needed. This category is applied to every ICD-9 and ICD-10 code within the aggregate code set in the IMAG tool.

Step 2: Briefly review the **source code**'s narrative description in the coding book. Note how it is categorized in its current structural format (ICD-9 or ICD-10: clinical and numeric relationships). Review the codes surrounding the source code in the coding book and assess organizational structure and level of specificity, as well as any coding guidelines or instructions that may apply.

Step 3: Identify the associated GEM mapping(s) in the "CMS GEMs Crosswalk" or in the IMAG tool.
- Locate the identified code(s) as the source code (If it is an ICD-9 code, look in the 9 to 10 GEMs; if it is an ICD-10 code, look first in the 10 to 9 GEMs). Identify and note all Target Codes associated with it in the GEM listings.
- Visually assess for other proximal and/or numerically similar mappings. This may include GEMs with Source Codes very similar to the original Source Code and/or GEMs with the same or very similar Target Codes. Make note of newly associated codes.

Step 4: Review the corresponding noted codes' narrative description(s) in the Target Code's respective coding book, on-line. Note the categorization in its current structural format (ICD-9 or ICD-10: clinical and numeric relationships), as well as any coding guidelines or instructions that may apply.

Step 5: Confirm GEM mapping and document in the IMAG tool; ***AND/OR*** add additional codes that the GEMS omitted; ***OR*** challenge the GEMs mapping by escalating the code.

- Return to the GEMs in the "CMS GEMs Crosswalk" or in the IMAG tool. Search for the initially identified code as the **Target Code** in the opposite GEMs listing (if it is an ICD-9 code, do a search in the 10 to 9 GEMs; if it is an ICD-10 code, do a search in the 9 to 10 GEMs).
- Then search for the new corresponding codes from the GEMs as the **Source Code** (from the opposite GEM list, where it was identified as the Target Code.).
- Continue to visually assess for other proximal and/or numerically similar mappings and make note. This may include Source Codes very similar to the original Source Code and/or with the same or very similar Target Codes. Make note of newly associated codes.

Step 6: Utilize the "Code Search Text" function on the "Code/Group Search" panel on the "Analysis" tab of the IMAG tool.

- Search for key words or phrases contained in the code descriptions you have identified, to direct you to other code sets or areas in ICD-10 that may have applicable codes for analysis.

Step 7: Crosswalk groupings in IMAG should be expanded to include all codes in the opposite set (ICD-9 to ICD-10 or vice versa) to the level of specificity in the opposite code set, whenever the source code is the optimal match for those more specific codes. These additional codes are often identified by checking the source code as a target code in the opposite set, or vice versa; and/or by looking in the code book; and/or by doing text searches in IMAG.

- If a GEM mapping cites one body part or region but other applicable body parts or regions are equally relevant, include all applicable body regions in the crosswalk groupings (*and category / aggregate set if applicable*).
- If a GEM mapping cites one trimester of pregnancy but other trimesters are equally relevant, include all applicable trimesters in the crosswalk groupings (*and category / aggregate set if applicable*).

- If a non-specific code maps in the GEMS only to another non-specific code in the opposite set, BUT there are more specific codes in the opposite set that map back to that non-specific code as well (i.e. when the source code is used as a target code), INCLUDE CROSS WALK GROUPINGS FOR ALL APPLICABLE CODES for which that non-specific code now has a more specific match. Do not, however, include codes in the crosswalk groupings that have better specific matches in the crosswalk – even though they may still be part of the *category* or *aggregate set*.
    - Every iCD-10 code should be matched to its best ICD-9 code (at least one) on an ICD-9 screen in IMAG, as well as on the ICD 10 screen in IMAG.
- If the GEM is being **challenged** *(the crosswalk is **disagreeing** with the GEMs as opposed to **expanding** the GEMs)*, escalated the code and document the rationale on the Escalate Screen in IMAG. If other codes relate similarly to the GEM challenge, create a "Coders' Group" in IMAG. The additional codes in the Coders' Group related to the escalated code are then given the status, "Await Rule".
    - When expanding GEM groupings to include additional body regions or pregnancy trimesters, this is considered a normal crosswalk. The code does not require escalation as a GEM challenge, unless the coder has a question or concern about the mapping or associated reference file or category.
    - When expanding GEM groupings to include additional more specific codes that do not have a better match in the opposite set, this is considered a normal crosswalk. The code does not require escalation as a GEM challenge, unless the coder has a question or concern about the mapping or associated reference file or category.
    - Always *escalate* a code, and make note of associated codes with the same question, to a QIF for further review when there are questions about the mapping, reference file, or any other editing/hard-coding issues*.* When unsure of a crosswalk, reference file, or category determination, err on the side of caution and escalate the code*. [After one's judgment is confirmed several times, the need to escalate codes may decrease.]*

Step 8: If a crosswalk grouping has combination groupings and scenarios requiring multiple codes, each code in the combination or scenario is documented in its appropriate grouping in IMAG. These crosswalk groupings are documented in both

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screens in IMAG (10 to 9 and 9 to 10) according to the logic and criteria defined in this document.

Step 9: Perform crosswalk mappings on each additional code that was associated to your initial Source or Target code.

- Perform Steps 3 – 7 above for each new code
- When the mapping leads to a code/description that is no longer within the focal range of the **original Source** or **original Target code**, do not include that code in this aggregate equivalent code set. Make note if this may belong to a closely associated aggregate equivalent code set.

Step 10: If a code has no associated GEM mapping verify this is correct by looking it up in the coding book and utilizing the "Code Search" function on the "Code/Group Search" panel on the "Analysis" tab of the IMAG tool. After performing this verification and no corresponding code is found then the code is closed out in IMAG with no cross walk.

Step 11: Review the larger code category(s) in ICD-9 as well as the primary related categories in ICD-10 in the code books and in IMAG. Assess if any related codes have been missed from either source.

Step 12: Monitor and follow up on resolution of escalated codes and associated rules to complete crosswalk groupings and categories.

Forms/Reports:
N/A

RFP References:
MED 10-001-C Amendment 3

Interfaces:
IMAG
MMIS

Attachments:
N/A

MED – ICD-10 Cross Walk Team
Completing Reference File on ICD-10 Codes

Purpose: The steps are intended to provide general process guidelines for completing the reference file on ICD-10 codes in IMAG (ICD-10 Mapping and Grouping Tool).

Identification of Roles:

Medical Coding Specialist – Maps ICD-9 to ICD-10 codes according to processes. Utilize attention to detail in analyzing, processing, and closing assigned codes/code sets. Seek assistance as needed. Monitor pending codes at least weekly and as appropriate.

Quality Improvement Facilitator (QIF) – Reviews identified aggregate code sets as processed by coders for completeness and accuracy. Monitors escalated and pending codes at least weekly and as appropriate.

Performance Standards:

Medical Coding Specialist – Maintains average personal (Internal Quality Control) IQC score of 95% or greater.

Quality Improvement Facilitator (QIF) – Completes IQC activities for team within assigned timeframes. Utilize attention to detail in analyzing, processing, and closing escalated codes/code sets. Is a resource to the rest of the team by providing answers to questions necessary to complete assignments.

Path of Business Procedure:

Step 1: Refer to document: "Code Status Criteria" for applying "Completed", "Pending", "Escalating", or "Awaiting Rule" status to ICD-10 codes.

Step 2: Complete cross-walk groupings per current "Crosswalk Process".

Step 3: Add applicable categories to the code.

Step 4: Compare the reference file of all ICD-9 codes that map to the ICD-10 code. (*Refer to Appendix, "Reference File Definitions" at the end of this document*)

Step 5: IMPORTANT: *When working on an aggregate code set OR a subsection of chapter codes, ALWAYS view the reference files for the ICD-9 codes around the*

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identified ICD-9 codes (utilize spreadsheet –[-..\..\..\Crosswalks\CORE Analysis Documents\MASTER ICD9 CODE LISTS\Copy of MMIS_Diag_Master_10172011.xlsx] to ascertain if codes related to this code have varying indicators. If there is apparent variance for any indicator for similar codes within a code grouping in ICD-9, assess the accuracy of those indicators. If there are questions about the reference file of the code or group of codes, escalate the code (or associate it to an escalated code) for further evaluation by the QIF or Manager.

Step 6: Codes with simple and straightforward cross-walks that have "standard reference files" (see definitions in Appendix below) may be completed and closed without escalation or additional consideration.

Step 7: Instructions for complex cross-walks and "non-standard" reference files:
- Review the established rules documented in IMAG, and on the associated "IMAG Rules" spreadsheet periodically, for established rules that are applicable to assigned code groups; and/or ask QIF's or manager about any associated IMAG rules.
- **If** the reference file for each associated ICD-9 code is identical for all indicators, you will ***generally*** complete the ICD-10 code with that same reference file.
  - Assess the rationale for associated Control Codes. If there is no apparent reasonable rationale for the associated Control Code, the code should be escalated for further review. Special care should be given when applying a Control Code 1 (Deny Payment) without confirming rationale. Control Codes 2 and 9 should also be evaluated for intent, and whether the need for review continues with the ICD-10 code.
  - Assess the rationale for other indicators; if any indicator in the ICD-9 code's reference file is conceptually incorrect, escalate the code for further evaluation. For example, many codes that have the emergency indicator in ICD-9 have been determined ineligible for the indicator in ICD-10 (e.g. blisters, splinters, and muscle strain; and all sequela [after-care] codes which did have the Emergency Indicator in ICD-9).
- **If** the reference files for associated ICD-9 codes differ from one another (a "mixed cross-walk") **and / or** there are questions about any of the indicators, escalate the ICD-10 code. Assemble a Coder's Group for other codes with a similar question.
  - **If** there is a "mixed cross-walk", but -- based on the nature of the code or the code description -- the reference file and indicators are clear, the code may be completed based on the coder's best judgment.

Step 8: Multiple codes with similar cross-walk or reference file questions should be tagged in a Coder's Group along with an escalated code, and marked with the status, "Awaiting rule."

Step 9: Once the cross-walk is documented in IMAG, and the reference fields and applicable categories are completed, the code should be marked as "Complete".

Step 10: Codes in these assigned chapters should be processed and completed (or pended/ escalated as indicated) in numerical, sequential order to the degree that it is practical.

Step 11: Notify the Manager or QIF when the assigned chapter is complete.

APPENDIX: Reference File Definitions

➢ The reference file for ICD-10 CM (diagnosis) codes is currently based on the structure of the reference file for ICD-9 codes in MMIS. The "standard" or "default" reference file for a diagnosis code on ICD-9 or ICD-10 is as follows:
- Accident Indicator – N
- Emergency Indicator – N
- Control Code Indicator – 0
- Sterilization Indicator –N
- Abortion Indicator – N
- Family Planning – N
- *[Minimum Age & Maximum Age – Not applicable at this time; plan to import from CMS Edits Manual in future data load]*
- *[Sex Indicator – Not applicable at this time; plan to import from CMS Edits Manual in future data load]*

➢ **The reference file indicators are defined as follows:**
- **Accident Indicator**
  - o Correlates with "trauma" codes for reporting purposes
  - o In ICD-9, includes codes 800 – 999.9 (minus 999.4); also includes *some* 700 codes
  - o Function of the Indicator in MMIS: If indicator is "Y", a letter of inquiry will be sent from the Revenue Collections Unit in pursuit of Third Party-Payer Liability (TPL).
- **Emergency Indicator**
  - o Services provided in a hospital, clinic, office, or other facility that is equipped to furnish the required care, after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity

(including severe pain), that the absence of immediate attention could reasonably be expected to result in:

- Placing the member's health in serious jeopardy,
- Serious impairment to bodily functions, or
- Serious dysfunction to any bodily organ or part.

o Per IAC 441-78.3(12) – "…The determination of whether a medical emergency exists will be based on the patient's medical condition including presenting symptoms and medical history prior to treatment or evaluation. Includes "*acute allergic reaction", and "acute, severe, respiratory distress".*

- Functions of the Indicator in MMIS -- If the indicator is a "Y"
    - No co-pay is taken for medical and institutional claims
    - Provider restrictions for Medipass and IowaCare recipients are lifted
- List of codes (which mirrors list in MMIS) is here: ..\..\Crosswalks\Ref File Indicators and NonAggregate Categories\Emergency Indicator\EmergencyDiagnosisCodes.xls

o Not all accidents and injury diagnosis codes are eligible for the emergency indicator. Many codes that have the emergency indicator in ICD-9 have been determined ineligible for the indicator in ICD-10 (e.g. blisters, splinters, and muscle strain; and all sequela [after-care] codes which did have the Emergency Indicator in ICD-9).

- Evaluation of these codes is done from the perspective of a "prudent layperson (*per guidance of IME Policy – June 2012)."*
- IME Medical Services Unit may be utilized as a reference for codes that are escalated in this regard.

- **Control Code**
    o Function in MMIS: Determines whether a code pays, suspends for review, or is denied
    - If the Control Code is "**0**", there are no edits
    - If the Control Code is **"1"**, the diagnosis is non-payable
    - If the Control Code is "**2**", the diagnosis requires review by Medical Services. There is a list of associated edits with Control Code 2 (see QIF or manager for more information)
    - If the Control Code is "**9**", the diagnosis requires that additional documentation be attached. There is a list of associated edits with Control Code 9 (see QIF or manager for more information)

- **Sterilization Indicator**
  - Function in MMIS: If the indicator is "Y", associated claims are bypassed from EOMB reporting.
- **Abortion Indicator**
  - Function in MMIS: If the indicator is "Y", associated claims are bypassed from EOMB reporting.
- **Family Planning Indicator**
  - Has already been addressed for all applicable codes by new Family Planning categories in IMAG
  - Function in MMIS:
    - If the indicator is "Y",
      - Associated claims are bypassed from EOMB reporting
      - The Category of Service goes to 60 (Family Planning) and splits the claim for federal report to CMS Family Planning at 90%.
      - N0 co-pay is taken for medical or institutional claims
      - Medipass edits are lifted

Forms/Reports:
N/A

RFP References:
MED 10-001-C Amendment 3

Interfaces:
IMAG
MMIS

Attachments:
N/A

MED – ICD-10 Cross Walk Team
Criteria for Category "Unspecified" Codes for Future Surveillance

Purpose: The steps are intended to provide general process guidelines for identifying the ICD-10 codes in IMAG (ICD-10 Mapping and Grouping Tool) that should qualify for the anticipated "Pay and Report" status.   This will allow for future trending and analysis of utilization, and possible targeted provider education. This category will not cause a code to suspend or be denied. Anticipated edit is to apply ONLY if the code is the primary or principal diagnosis on a claim.

Identification of Roles:
Medical Coding Specialist – Maps ICD-9 to ICD-10 codes according to processes. Utilize attention to detail in analyzing, processing, and closing assigned codes/code sets. Seek assistance as needed. Monitor pending codes at least weekly and as appropriate.
Quality Improvement Facilitator (QIF) – Reviews identified aggregate code sets as processed by coders for completeness and accuracy. Monitors escalated and pending codes at least weekly and as appropriate.

Performance Standards:
Medical Coding Specialist – Maintains average personal (Internal Quality Control) IQC score of 95% or greater.
Quality Improvement Facilitator (QIF) – Completes IQC activities for team within assigned timeframes. Utilizes attention to detail in analyzing, processing, and closing escalated codes/code sets. Is a resource to the rest of the team by providing answers to questions necessary to complete assignments.

Path of Business Procedure:

Step 1: Apply IMAG CATEGORY: "**Unspecified Codes for Future Surveillance**" to "unspecified" codes IF:
- There are other more specific codes related to body site or laterality *OR*
- There are other more specific codes related to pregnancy stage, trimester, or fetus #, *OR*
- There is an option of "Other…." or "Other Specified…" in addition to the "Unspecified" code option
  AND
- There are NO specific diagnoses listed under the code as examples that would be appropriate utilization of the code

Step 2: Do NOT apply this category IF:
- There is *not* a more appropriate code option (e.g. COPD J44.9) *OR*
- There ARE specific diagnoses listed under the code as examples that would be appropriate utilization of the code

Step 3: Some ""Unspecified" codes have an apparent example below that simply repeats the diagnosis description, followed by "NOS". This is *not* an example of an appropriate utilization of the code, and should not eliminate this code from the "Unspecified" Category. Neither does it qualify the code for category; the code should still be evaluated according to this entire criteria.

Step 4: When in question, escalate the code for further review.

NOTE: An additional rule regarding this category was added to IMAG (ICD-10 Mapping And Grouping Tool) on 4/26/2012, Rule #R0019 – Other & Unspecified Codes: "Per ICD-10 Coding guidelines codes titled "other" or "other specified" are for use when the information in the medical record provides detail for which a specific code does not exist. Unspecified codes are for use when the information in the medical record is insufficient to assign a more specific code. For those categories for which an unspecified code is not provided, the "*other specified" code may represent both other and unspecified*. An ICD-10 "other" or "other specified" code should be cross-walked to an "other" or "other specified" ICD-9 code, not an "unspecified" code. If the category does not include an "unspecified" code then it is appropriate to cross-walk an "unspecified" code to an "other" code.

If the GEMs go against the above rule, please over ride them using Rule # R0019 above.

[Example: ICD-10 code I70.239 (Atherosclerosis of native arteries of right leg with ulceration of unspecified site) is a combination code and cross-walks to 440.23 (Atherosclerosis of the extremities with ulceration) & 707.19 (Ulcer of other part of lower limb) according to the GEMs. However, there is a code for ulcer of lower limb, unspecified (707.10) that is more appropriate. 707.10 only maps to L97909 (an ulcer code); it did not map to any of the combination codes in the circulatory chapter. Therefore, we did not follow the GEMs in this case and only mapped to 707.10 & 440.23.]

Forms/Reports:
N/A

RFP References:
MED 10-001-C Amendment 3

Interfaces:
IMAG
MMIS

Attachments:
N/A

MED – ICD-10 Cross Walk Team
Procedure Code Cross Walk Process

Purpose: The steps are intended to provide general process guidelines for cross walking the ICD-9 procedure codes to the ICD-10 procedure codes.

Identification of Roles:

Medical Coding Specialist – Maps ICD-9 to ICD-10 codes according to processes. Utilize attention to detail in analyzing, processing, and closing assigned codes/code sets. Seek assistance as needed. Monitor pending codes at least weekly and as appropriate.

Quality Improvement Facilitator (QIF) – Reviews identified aggregate code sets as processed by coders for completeness and accuracy. Monitors escalated and pending codes at least weekly and as appropriate.

Performance Standards:

Medical Coding Specialist – Maintains average personal (Internal Quality Control) IQC score of 95% or greater.

Quality Improvement Facilitator (QIF) – Completes IQC activities for team within assigned timeframes. Utilizes attention to detail in analyzing, processing, and closing escalated codes/code sets. Is a resource to the rest of the team by providing answers to questions necessary to complete assignments.

Path of Business Procedure:

Step1: Identify the assigned code or "*aggregate code set*"* --

- From assigned list of codes/code sets/chapters **OR**
- Per "*requirement*"** from ICD-10 Project Group, Medical Services, or another IME Unit

Note: If the assignment relates to a requirement, first identify the category(s) or the reason for the selected indicator(s) [often relevant to the MMIS reference file; special edits; or IME policy related to the code] which are the focus of this code set. Categories for aggregate codes sets, or requirements, will be finalized and entered into IMAG tool (ICD-10 Mapping and Grouping Tool) by the Quality Improvement Facilitator (QIF) or Manager. Examples:

- *Category: Transplant*
- *Category: Gastroplasty*

The category is defined in IMAG by the manager or QIF, and the status of the category is updated as needed. This category is applied to every ICD-9 and ICD-10-PCS code within the aggregate code set in the IMAG tool.

Step 2: Begin with typing the first 3 digits of the code set you are working on in the search box in iMAG. Click the button "Save This Search List" and retrieve from the iMAG folder in the C-drive. Save this document to your personal folder and use as your "working document".

Step 3: Type the first code from the "working document" into the search box and select it.

Step 4: Briefly review the **source code**'s narrative description in the coding book. Note how it is categorized in its current structural format (ICD-9 or ICD-10-PCS: clinical and numeric relationships). Review the codes surrounding the source code in the coding book and assess organizational structure and level of specificity, as well as any coding guidelines or instructions that may apply.

Step 5: Identify the associated GEM mapping(s) in the "CMS GEMs Crosswalk" or in the IMAG tool.
- In the GEMs locate the identified code(s) as the source code (If it is an ICD-9 code, look in the 9 to 10 GEMs; if it is an ICD-10 code, look first in the 10 to 9 GEMs). Identify and note all Target Codes associated with it in the GEM listings. In the iMAG tool, pull up the GEM file in the analysis tab, and enter the code.
- Visually assess for other proximal and/or numerically similar mappings. This may include GEMs with Source Codes very similar to the original Source Code and/or GEMs with the same or very similar Target Codes. Make note of newly associated codes.

Step 6: Review the corresponding noted codes' narrative description(s) in the Target Code's respective coding book, on-line. Note the categorization in its current structural format (ICD-9 or ICD-10: clinical and numeric relationships), as well as any coding guidelines or instructions that may apply.

Updated 06/13/14

Step 7: Utilize your "working document" to note which PCS codes the ICD-9 code refers to.

Step 8: Confirm GEM mapping and document in the IMAG tool; ***AND/OR*** add additional codes that the GEMS omitted; ***OR*** challenge the GEMs mapping by escalating the code.

- Return to the GEMs in the "CMS GEMs Crosswalk" or in the IMAG tool. Search for the initially identified code as the **Target Code** in the opposite GEMs listing (if it is an ICD-9 code, do a search in the 10 to 9 GEMs; if it is an ICD-10 code, do a search in the 9 to 10 GEMs).
- Then search for the new corresponding codes from the GEMs as the **Source Code** (from the opposite GEM list, where it was identified as the Target Code.   ).
- Continue to visually assess for other proximal and/or numerically similar mappings and make note. This may include Source Codes very similar to the original Source Code and/or with the same or very similar Target Codes. Make note of newly associated codes.

Step 9: Utilize the "Code Search Text" function on the "Code/Group Search" panel on the "Analysis" tab of the IMAG tool.

- Search for key words or phrases contained in the code descriptions you have identified, to direct you to other code sets or areas in ICD-10 that may have applicable codes for analysis.

Step 10: Crosswalk groupings in IMAG should be expanded to include all codes in the opposite set (ICD-9 to ICD-10-PCS or vice versa) to the level of specificity in the opposite code set, whenever the source code is the optimal match for those more specific codes. These additional codes are often identified by checking the source code as a target code in the opposite set, or vice versa; and/or by looking in the code book; and/or by doing text searches in IMAG.

- If a GEM mapping cites one body part or region but other applicable body parts or regions are equally relevant, include all applicable body regions in the crosswalk groupings (*and category / aggregate set if applicable*).
- If the GEM is being ***challenged*** *(the crosswalk is **disagreeing** with the GEMs as opposed to **expanding** the GEMs)*, escalate the code and document the rationale on the Escalate Screen in IMAG. If other codes relate similarly to the GEM challenge, create a "Coders' Group" in IMAG. The additional codes in the Coders' Group related to the escalated code are then given the status, "Await Rule".

- When expanding GEM groupings to include additional body regions this is considered a normal crosswalk. The code does not require escalation as a GEM challenge, unless the coder has a question or concern about the mapping or associated reference file or category.
- Always *escalate* a code, and make note of associated codes with the same question, to a QIF for further review when there are questions about the mapping, reference file, or any other editing/hard-coding issues. When unsure of a crosswalk, reference file, or category determination, err on the side of caution and escalate the code. *[After one's judgment is confirmed several times, the need to escalate codes may decrease.]*

- If the ICD-10 PCS code cross walks to more than one ICD-9 code with different control codes, they should be escalated for determination of the correct control code. *For example, if one ICD-9 code carries A0053 (deny) and the other A0055 (suspend for medical), escalate the code. (Create a coder group if necessary and await-rule the associated rules.)*

Step 11: If a crosswalk grouping has combination groupings and scenarios requiring multiple codes, each code in the combination or scenario is documented in its appropriate grouping in IMAG. These crosswalk groupings are documented in both screens in IMAG (10 to 9 and 9 to 10) according to the logic and criteria defined in this document.

Step 12: If several ICD10-PCS codes crosswalk to the same ICD-9 code and they all have the same reference file, the "Replicate Codes" feature may be used. This is found under the Admin tab/Coder screen in iMAG. The coder must first complete the base code with the correct information and then go into the Admin tab/Coder screen. The type of code must first be selected and then enter the base code in the "Select Base Code" field. Next the coder clicks on the "Select code to Replicate" button and chooses all the codes she wishes to be replicated. If the code has already been completed it will show up in the "Codes Not Replicated" field.

Step 13: Perform crosswalk mappings on each additional code that was associated to your initial Source or Target code.
- Perform Steps 3 – 12 above for each new code
- When the mapping leads to a code/description that is no longer within the focal range of the **original Source** or **original Target code**, do not include that code in this aggregate equivalent code set. Make note if this may belong to a closely associated aggregate equivalent code set.

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Step 14: Keep track of codes that have been worked on your "working document", as IMAG does not currently show the previous code once it is saved.

Step 15: Review the larger code category(s) in ICD-9 as well as the primary related categories in ICD-10 in the code books and in IMAG. Assess if any related codes have been missed from either source.

Step16: Monitor and follow up on resolution of escalated codes and associated rules to complete crosswalk groupings and categories.

Forms/Reports:
N/A

RFP References:
MED 10-001-C Amendment 3

Interfaces:
IMAG
MMIS

Attachments:
N/A

MED – ICD-10 Cross Walk Team
Process for Completing Reference File on ICD-10-PCS Codes

Purpose: The steps are intended to provide general process guidelines for completing the reference file on ICD-10 codes in IMAG (ICD-10 Mapping and Grouping Tool).

Identification of Roles:

Medical Coding Specialist – Maps ICD-9 to ICD-10 codes according to processes. Utilize attention to detail in analyzing, processing, and closing assigned codes/code sets. Seek assistance as needed. Monitor pending codes at least weekly and as appropriate.

Quality Improvement Facilitator (QIF) – Reviews identified aggregate code sets as processed by coders for completeness and accuracy. Monitors escalated and pending codes at least weekly and as appropriate.

Performance Standards:

Medical Coding Specialist – Maintains average personal (Internal Quality Control) IQC score of 95% or greater.

Quality Improvement Facilitator (QIF) – Completes IQC activities for team within assigned timeframes. Utilizes attention to detail in analyzing, processing, and closing escalated codes/code sets. Is a resource to the rest of the team by providing answers to questions necessary to complete assignments.

Path of Business Procedure:

Step 1: Refer to document: "Code Status Criteria" for applying "Completed", "Pending", "Escalating", or "Awaiting Rule" status to ICD-10 codes.

Step 2: Complete cross-walk groupings per current "Crosswalk Process".

Step 3: Add applicable categories to the code.

Step 4: Compare the reference file of all ICD-9 codes that map to the ICD-10 PCS code. (*Refer to Appendix, "Reference File Definitions" at the end of this document*)

Step 5: IMPORTANT: *When working on an aggregate code set OR a subsection of chapter codes, ALWAYS view the reference files for the ICD-9 codes around the*

identified ICD-9 codes (utilize spreadsheet –[-..\..\..\Crosswalks\CORE Analysis Documents\MASTER ICD9 CODE LISTS\Copy of MMIS_Diag_Master_10172011.xlsx] to ascertain if codes related to this code have varying indicators. If there is apparent variance for any indicator for similar codes within a code grouping in ICD-9, assess the accuracy of those indicators. If there are questions about the reference file of the code or group of codes, escalate the code (or associate it to an escalated code) for further evaluation by the QIF or Manager.

Step 6: Codes with simple and straightforward cross-walks that have "standard reference files" (see definitions in Appendix below) may be completed and closed without escalation or additional consideration.

Step 7: Instructions for complex cross-walks and "non-standard" reference files:
- Review the established rules documented in IMAG, and on the associated "IMAG Rules" spreadsheet periodically, for established rules that are applicable to assigned code groups; and/or ask QIF's or manager about any associated IMAG rules.
- If the reference file for each associated ICD-9 code is identical for all indicators, you will *generally* complete the ICD-10-PCS code with that same reference file.
   - Assess the rationale for other indicators; if any indicator in the ICD-9 code's reference file is conceptually incorrect, escalate the code for further evaluation.
- If the reference files for associated ICD-9 codes differ from one another (a "mixed cross-walk") and / or there are questions about any of the indicators, escalate the ICD-10-PCS code. Assemble a Coder's Group for other codes with a similar question.
   - If there is a "mixed cross-walk", but -- based on the nature of the code or the code description -- the reference file and indicators are clear, the code may be completed based on the coder's best judgment.

Step 8: Multiple codes with similar cross-walk or reference file questions should be tagged in a Coder's Group along with an escalated code, and marked with the status, "Awaiting rule."

Step 9: Once the cross-walk is documented in IMAG, and the reference fields and applicable categories are completed, the code should be marked as "Complete".

Step 10: Codes in these assigned chapters should be processed and completed (or pended/ escalated as indicated) in numerical, sequential order to the degree that it is practical.

Step 11: Notify the Manager or QIF when the assigned chapter is complete.

APPENDIX: Reference File Definitions

➤ The reference file for procedures, as documented by the Crosswalk Team, will have three fields with these default values:

- *Once in a lifetime (Life Svc)* – <u>N</u> *(No) {New field in IMA*
- *Prior Authorization (PA_Ind)* – <u>N</u> *(No)*
- *Control Code (CC)* – *0 (None, or "Pay")*

➤ The PCS reference file Indicators are defined as follows

- <u>Once in a Lifetime (Life Svc field in IMAG)</u> – This has not been in use for ICD-9 procedure codes in our current system. It was only in use for CPT codes in the past. It will be for procedures such as appendectomy, or left arm amputation, where a procedure can only be performed one time within an individual's lifetime.
  - A group of "Once in a Lifetime" procedure codes have been suggested by Policy and Medical Services. These have been placed in IMAG Category A0116 and routed for approval after completion of crosswalk.

3. <u>Prior Authorization (PA Ind field in IMAG)</u> – There are three options for Prior Authorization in our current system: I (IFMC), R, N. This will be changed with ICD-10 to Y (Yes - prior auth is required) and N (No prior auth required)

4. <u>Control Code</u> – (These were inadvertently not integrated into IMAG, so have been created as new IMAG Categories. The categories have been pre-populated with the ICD-9 codes that have a Control Code other than the default value of "0")*.* The Control Code determines whether a code pays, suspends for review, or is denied
   - A0053 Procedure <u>Control Code D</u> (Deny) -- If the Control Code is a "D, the procedure is non-payable. Escalate these codes if the reason that the procedure should deny is unclear.
   - A0054 <u>Procedure Control Code R</u> (Suspend for review [*Core, then Medical*]) *OR* A0055 <u>Procedure Control Code S</u> (Suspend for review [*Medical*]) -- Give consideration to greater specificity and look at code groups rather than exclusively "code-to-code" cross walks. Escalate if you are unsure if the CC in ICD-9 is appropriate for the ICD-10 code.
   - A0056 <u>Procedure Control Code X</u> (Exception to Policy) -- If the Control Code is "X", the procedure requires an Exception to Policy (ETP). There is only one

code at this time with a control code of X; but the plan is to utilize this function more in the future.

Forms/Reports:
N/A

RFP References:
MED 10-001-C Amendment 3

Interfaces:
MMIS
IMAG

Attachments:
N/A

MED – ICD-10 Cross Walk Team
Process for Creating a Coders Group

Purpose: The steps are intended to provide general process guidelines for completing creating a coders group of related ICD-10 codes in IMAG (ICD-10 Mapping and Grouping Tool).

Identification of Roles:

Medical Coding Specialist – Maps ICD-9 to ICD-10 codes according to processes. Utilize attention to detail in analyzing, processing, and closing assigned codes/code sets. Seek assistance as needed. Monitor pending codes at least weekly and as appropriate.

Quality Improvement Facilitator (QIF) – Reviews identified aggregate code sets as processed by coders for completeness and accuracy. Monitors escalated and pending codes at least weekly and as appropriate.

Performance <u>Standards:</u>

Medical Coding Specialist – Maintains average personal (Internal Quality Control) IQC score of 95% or greater.

Quality Improvement Facilitator (QIF) – Completes IQC activities for team within assigned timeframes. Utilizes attention to detail in analyzing, processing, and closing escalated codes/code sets. Is a resource to the rest of the team by providing answers to questions necessary to complete assignments.

Path of Business Procedure:

Step 1: A Coders group is created to batch groups of codes together in one location for easy access. There are several reasons why a coder would create a Coders Group:

- To batch several codes together to analyze for category placement. (i.e.: all unspecified codes in a section)
- For quick referencing a number of codes that match similar attributes (i.e.: All codes in the pregnancy section that have 5th digits of 2 and 4)
- For codes with an identical question as a code that has been escalated (awaiting rule). So, when the answer is returned and/or a rule is made on the escalated code; this can easily be applied to all similar codes.

Step 2: Creating a Coders Group

- Under "ANALYSIS" tab in IMAG, click on "Categories". Then click the "Group and Categories- Create/Modify" button.

Updated 06/13/14

- Fill in bubble next to "Coders Group" and click the "Create New Group" button.
    - The Code will auto populate to the next available code.
- Label coders group with your initials- short description of group. What is this group for?
    - If the group is awaiting a rule on an escalated code, identify the escalated code for ease of use. (i.e.: MJH- 715.8- code set, mapping question. M15.3 escalated)
- Click the "SAVE" button. A pop up box indicating "Code details saved" will appear. Click "OK".
- Exit out of that screen, and open the "Code/Group Search" Screen.

Step 3: Editing a Coders Group
- Under "ANALYSIS" tab in IMAG, click on "Categories". Then click the "Group and Categories- Create/Modify" button.
- Fill in bubble next to "Coders Group" and click the "EDIT or VIEW" button.
- Select the drop down button and scroll to the desired code you wish to edit.
- Edit the Short Description, and click "SAVE" when you are finished.
- If you wish to delete the Coders Group, select the box next to "Delete Group"
- A pop up box indicating "Code details saved" will appear. Click "OK"

Step 4: Viewing / Modifying a Coders Group
- Under "ANALYSIS" tab in IMAG, click on "Code/Group Search" Screen.
- Fill in bubble next to "Coders Group" (on right side) and click the "Get Group" button.
- Click the drop down arrow and scroll to the Coders Group you wish to view. Click "View".
    - The ICD 9 Codes and ICD 10 Codes columns will populate with any codes previously entered.
- To modify the codes, click the "Edit" Button.
- On the left side, in the "Code Search Text" box, type in the first few digits of the codes you are looking for.
    - The codes containing the digits will populate in the columns.
- Double click on the codes you wish to add to the Coders Group.
    - The codes you select will populate in the columns on the right.
- Repeat steps 10 and 11 as necessary, until you have added all codes required to the Coders Group.
    - You can return to the editing portion at any time to add or remove codes from your group.

- In order to remove a code from the Coders Group, select the code from the columns on the right, and click the "Clear ICD9 Code" or "Clear ICD10 Code" button, depending on which column the code is in.
- When you are finished, and wish to save the Coders Group, click the "Done Editing" button on the right side.

Step 5: Copy/Paste Information:
- If you wish to copy contents of the Coders Group, click the "To XL Sheet".
- If there is no file already saved on the C drive, a pop up box will appear that says, "The XL file is saved to C:\iMAg\GroupDetails.xlsx".   Click "OK".
- If a file is already on the C drive, a pop up box will appear that says, "A file named 'C: IMAg\GroupDetails.xlsx' already exists in this location. Do you want to replace it?" Click "Yes".
- From the start menu, click on "My Computer", and double click on "Local Disk (C :)". Double click on iMAG folder and double click "Group Details" file.
- Save the file under a different name and choose the location you would like to save to.
- Right click on the file in iMAG, and select "delete".

Forms/Reports:
N/A

RFP References:
MED 10-001-C Amendment 3

Interfaces:
MMIS
IMAG

Attachments:
N/A

Updated 06/13/14

MED – ICD-10 Cross Walk Team
Test Case Writing Process

Purpose: These steps provide general process guidelines on how to write Test cases using the template in TFS (Team Foundation Server) to the level of specificity that the test case can be executed successfully.

Identification of Roles:

Medical Coding Specialist – Maps ICD-9 to ICD-10 codes according to processes. Utilize attention to detail in analyzing, processing, and closing assigned codes/code sets. Seek assistance as needed. Monitor pending codes at least weekly and as appropriate.

Quality Improvement Facilitator (QIF) – Reviews identified aggregate code sets as processed by coders for completeness and accuracy. Monitors escalated and pending codes at least weekly and as appropriate.

Performance Standards:

Medical Coding Specialist – Maintains average personal (Internal Quality Control) IQC score of 95% or greater.

Quality Improvement Facilitator (QIF) – Completes IQC activities for team within assigned timeframes. Utilizes attention to detail in analyzing, processing, and closing escalated codes/code sets. Is a resource to the rest of the team by providing answers to questions necessary to complete assignments.

Path of Business Procedure:

The template in the following template in Team Foundation Server (TFS) is used in the ICD-10 Project to write test cases:

Project: IME ICD-10
Server: dhsvstfs
Query: [None]

ID	Work Item Type	Title	Description	IME Test Setup Instructions	IME Test Execution Steps	IME Test Expected Results - HTML	IME System Release	IME System	IME Requirements ID	IME Affected Units	IME Owner Unit

Step 1: Leave the ID blank. TFS will auto-fill the Test Case ID number when uploaded.

Step 2: Fill in "Test Case" under Work Item Type'.

Step 3: Under the column named "Title" fill in the name of the test case.
- Include the TFS requirement ID being tested in your title.
- If this is a negative test case, label as such in the title.

Step 4: Under the column named "Description" fill in the requirement the test case is based off of.

Step 5: Under the column named "IME Test Setup Instructions" fill in the type of claim, member age, plan type, etc. that CORE needs to provide for the scenario.

Step 6: Under the column named "IME Test Execution Steps" list all steps.
- Test cases need to reflect the requirement and give very detailed, in-depth instructions on how to execute the test case.
- Include steps to navigate between screens in MMIS.
- Include steps on saving screenshots and where to upload them.
- Include steps regarding requesting batches, screen shots, or reports from CORE.
  - When requesting from CORE, specify what it is that is needed, include both the test case ID as well as the TCN, and request how you would like to receive information (i.e.: email, OnBase, etc.).

Step 7: Under the column named "IME Test Expected Results" list specifically what the tester is to determine from this test case.
- i.e.: Specific edit must post, copay will be applied, etc.
- If more than one expected result, number them.
- Include the requirement ID the result is attached to (if more than one is being tested).

Step 8: Under the column named "IME System Release: enter the Iteration number.

Step 9: Under the column named "IME System" enter MMIS.

Step 10: Under the column named "IME Requirements ID" list the relevant requirement ID number(s) from TFS.

Step 11: Under the column named "IME Affected Units" enter Medical Services.

Step 12: Under the column named "IME Owner Unit" enter Medical Services.

➢ Test case example:
  o Requirement: "The system must not post an edit for Institutional claims when the reference file diagnosis control code value = 0". (TFS Requirement ID #8459)
  o ID- blank
  o Work Item Type- 'Test Case'.
  o Title- '8459- Reference file control 0 Inpt.
  o Description- 'The system must not post an edit for Institutional claims when the reference file diagnosis control code value = 0'.
  o IME Test Setup Instructions- 'Institutional IP claim'.
  o IME Test Execution Steps-
    1. Log in to MMIS
    2. On the Iowa Medicaid Management Information screen enter a 2 in the Application- Number field.
    3. Press Enter.
    4. Key TCN XXXXX starting in the Claim-Input-Medium-Indicator field (the tcn numbers will display in the appropriate fields as you key).
    5. Press Enter.
    6. Key diagnoses in the following order: XXXXX, XXXXX, XXXXX
    7. Press F12 key and enter.
    8. Take a screen shot:
       a. Press Ctrl/Alt/Print Scrn
       b. Open a new Word document
       c. Press Ctrl/V
       d. Save document to your computer, using the test case number as the name.
    9. Validate expected results.
    10. Document findings in TFS.
    11. Upload screen shot document from your computer to SharePoint.
       a. All documentation for testing is saved in SharePoint under: XXXXXXXXXXXXXXXX.
  o IME Test Expected Results- 'Results in claim NOT posting an edit 445,453,461,469,477,447,455,463,471,479,349,993,987,446,454,462,470, or 478; however, other edits may post.' *
  o IME System Release- 'Iteration X'.
  o IME System- 'MMIS'.
  o IME Requirements ID- '8459'.
  o IME Affected Units- 'Medical Services'.
  o IME Owner Unit- 'Medical Services'.

➢ Do not attempt to reformat any of the cells in the template. This will cause the spreadsheet to become corrupted. It is helpful if you save a copy of the spreadsheet on your desktop while working on your test cases. After all of your test cases have been written then you can upload the document in Share point.

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> ➢ There are times when additional information is needed (see IME Test Expected Results). Discuss with correct unit to obtain the information required to successfully perform the test. (ie: what edits are NOT to post to this claim?)

Step 13: DO NOT load to testing environment until all test cases are completed! Click "No" when prompted. (See example below.)
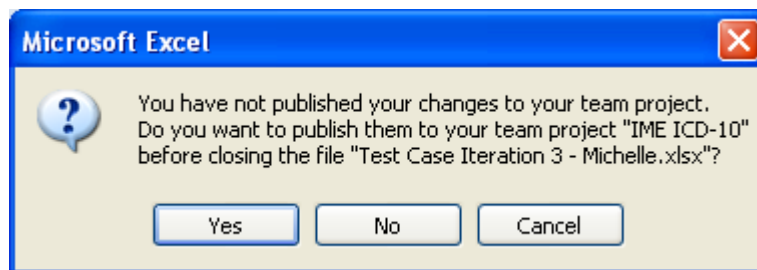
Step 14: After all test cases have been completed THEN load all of your test cases into TFS at the same time. Open excel spreadsheet in SharePoint. Exit to bring up above pop up. Select 'Yes'.

      i. The system will assign an ID to every test case.
     ii. Save spreadsheet in SharePoint.

Forms/Reports:
N/A

RFP References:
MED 10-001-C Amendment 3

Interfaces:
IMAG
MMIS
TFS
Share Point

Attachments:
N/A

MED – ICD-10 Cross Walk Team
Test Case Execution Process

Purpose: The steps are intended to provide general process guidelines for provide on how to execute test cases and documentation of the test case results.

Identification of Roles:

Medical Coding Specialist – Maps ICD-9 to ICD-10 codes according to processes. Utilize attention to detail in analyzing, processing, and closing assigned codes/code sets. Seek assistance as needed. Monitor pending codes at least weekly and as appropriate.

Quality Improvement Facilitator (QIF) – Reviews identified aggregate code sets as processed by coders for completeness and accuracy. Monitors escalated and pending codes at least weekly and as appropriate.

Performance Standards:

Medical Coding Specialist – Maintains average personal (Internal Quality Control) IQC score of 95% or greater.

Quality Improvement Facilitator (QIF) – Completes IQC activities for team within assigned timeframes. Utilizes attention to detail in analyzing, processing, and closing escalated codes/code sets. Is a resource to the rest of the team by providing answers to questions necessary to complete assignments.

Path of Business Procedure:

Step1: To log into the MMIS Test Environment follow these steps:

- Open MMIS
- Hit the F3 button.
- Do not click anywhere, just type the following: logon cdmcicsc
- Hit the ENTER button.
- In the USERID field type your personal 'dss….' number
- In the PASSWORD field type your personal password
- Hit the ENTER button.
- Hit the ENTER button again.
- Do not click anywhere and type the following: iowa
- Hit the ENTER button.
- In the USERID field type: YOUR TEST GROUP USER NAME
- In the PASSWORD field type: YOUR TEST GROUP PASSWORD

- If the following screen comes up, you are in the test environment:
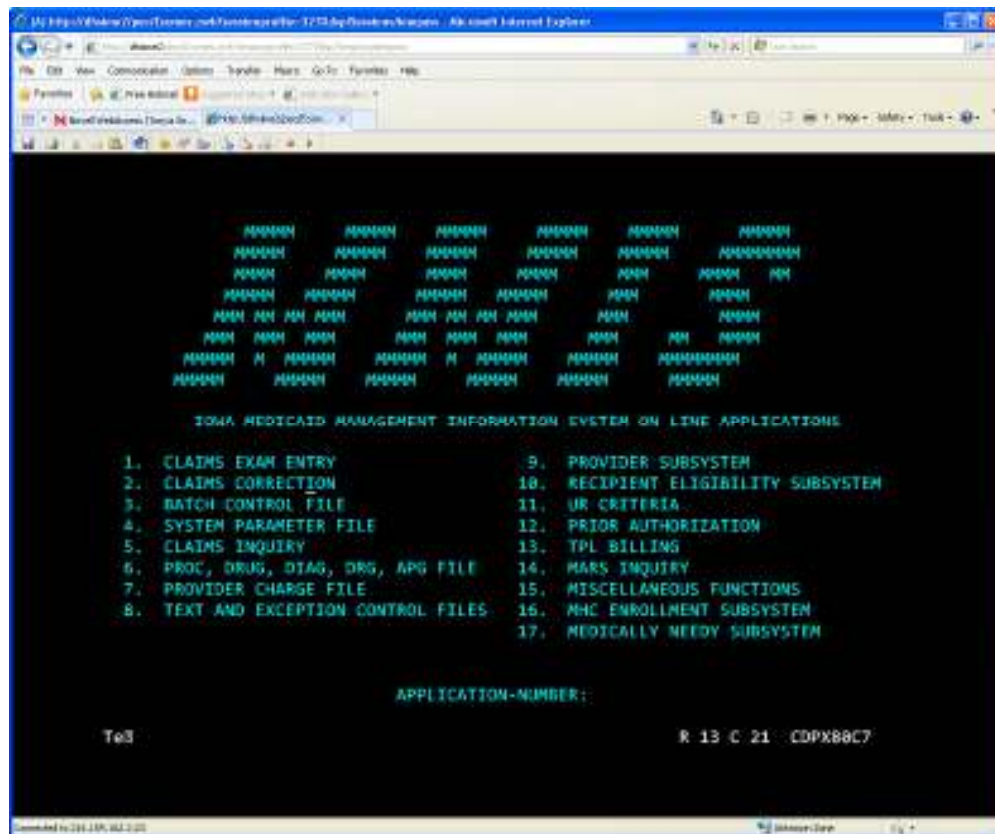
Step 2: Open TFS, *Work Items*, *My Queries* and the title of the type of testing that you are working on.
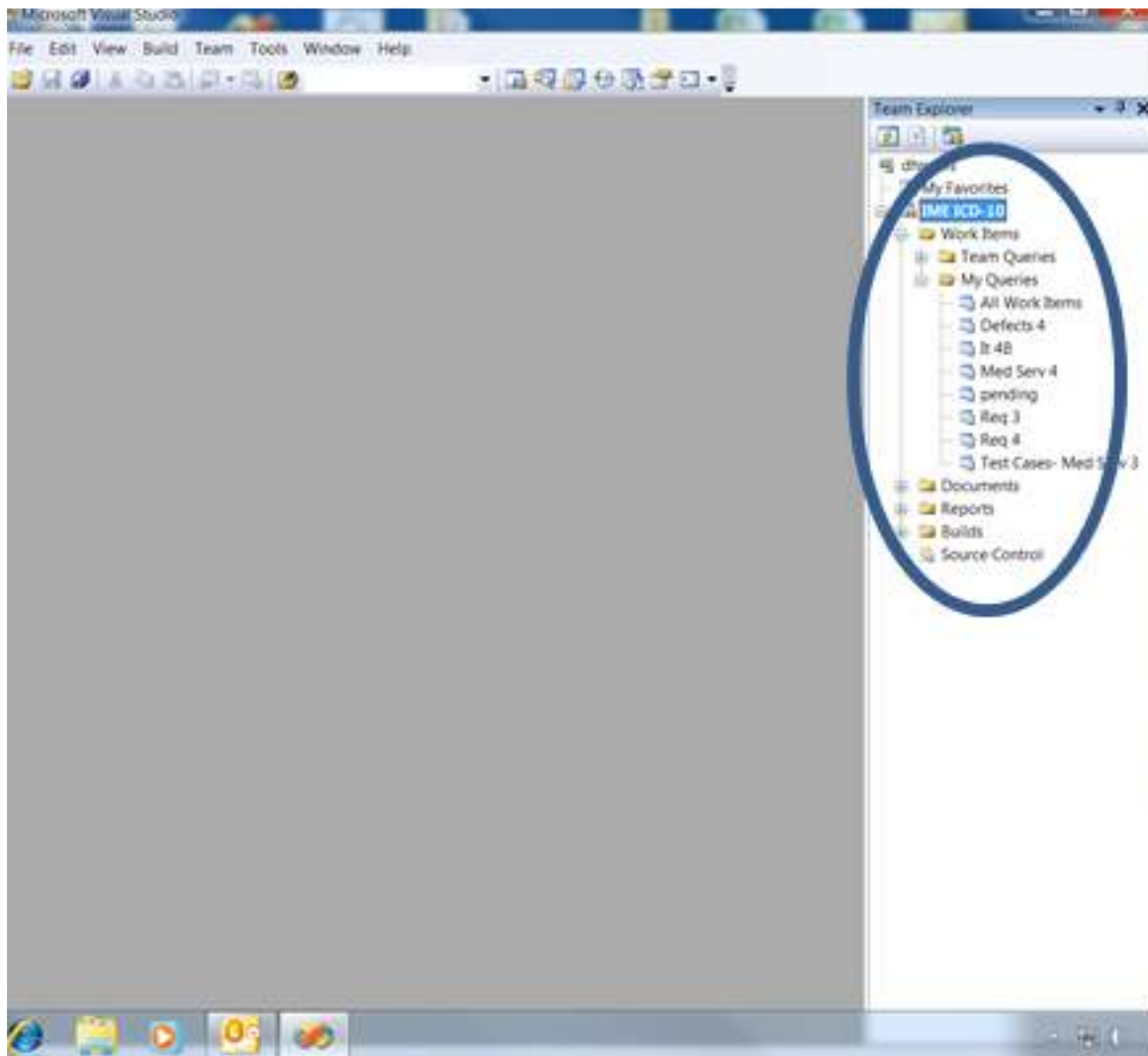
Step 3: Double click to open the Test Case # of the test case you will be running.
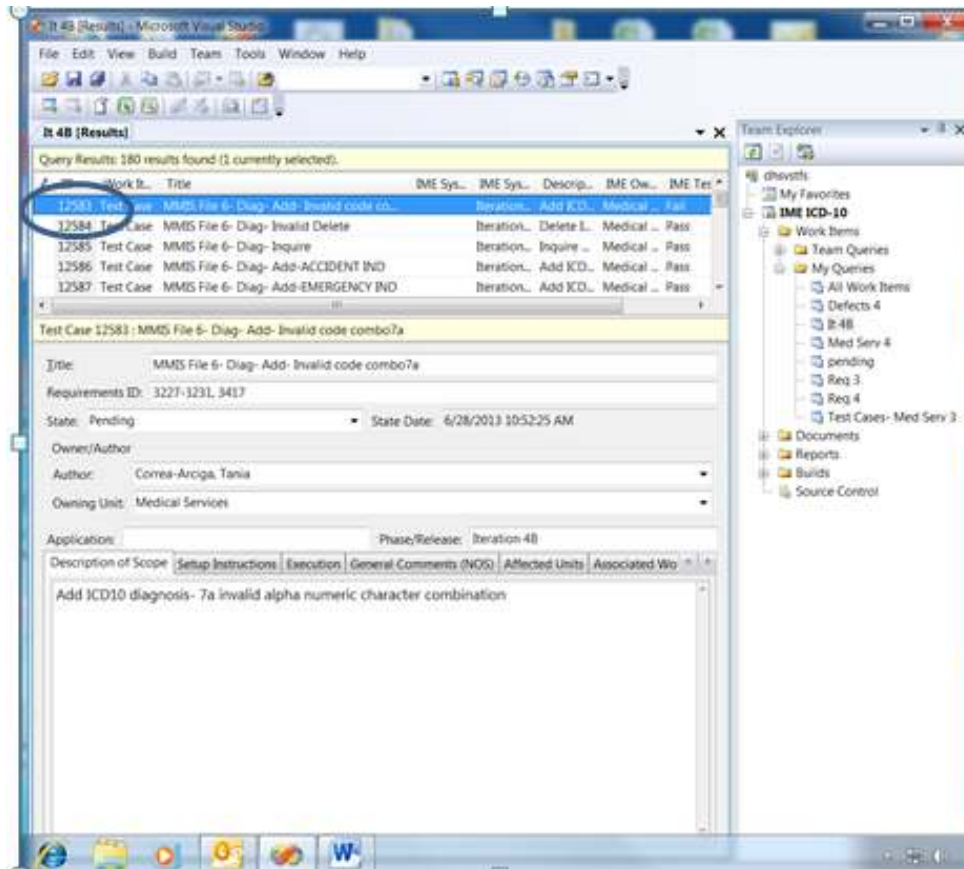
Step 4: After opening the test case, choose the *Execution* tab and then choose *Steps*. Follow the steps in the MMIS testing environment to execute the test. Open *Expected Results* to verify you have these results.
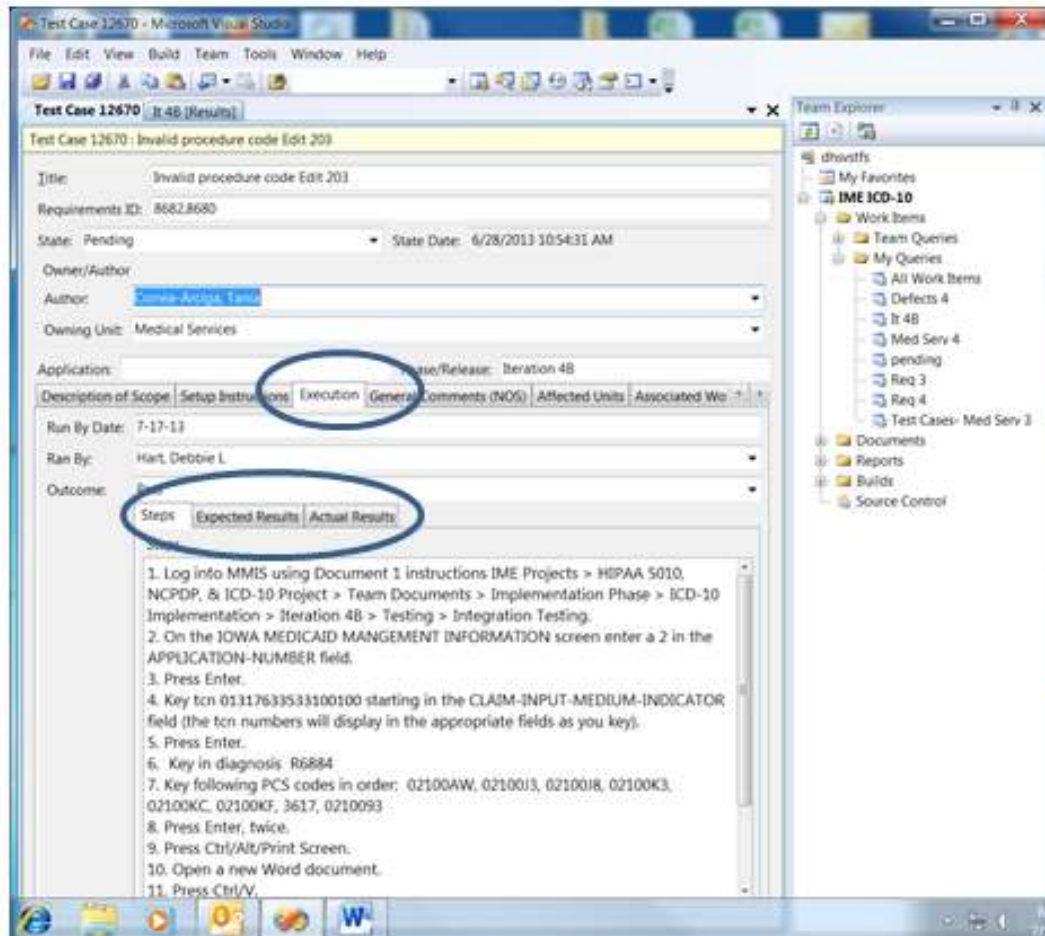
Step 5: Follow the steps below to save a copy of a screen shot of the MMIS claim screen to record the test case results.

To create testing screen shot of claim screen:

1. Press Ctrl/Alt/Print Screen.
2. Open a new Word document.
3. Press Ctrl/V.
4. Save document to your computer, using the test case number as the name.
5. Upload document from your computer to Share point.

Step 6: If you have the same results as the *Expected Results*, the test case passes. Open the *Actual Results* tab and document "results as expected". Directly above the *Actual Results* tab, fill in *Run by Date*, *Ran By*, and *Outcome*.

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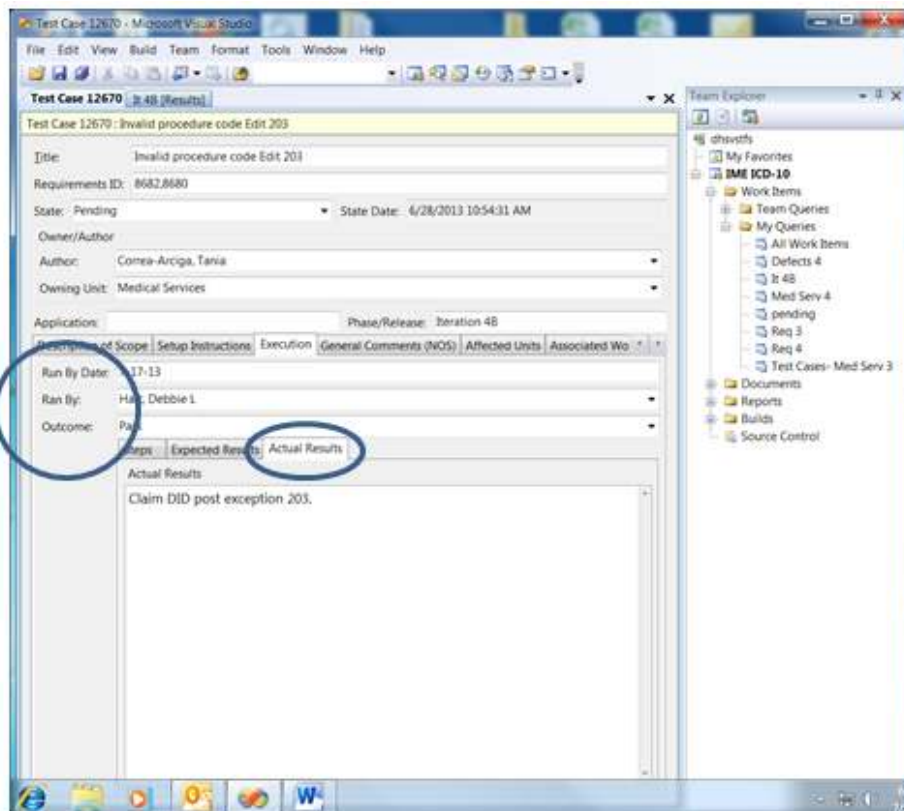
Step 7: At the top of the page, right click on the test case number, when the drop down opens, save and close the test case.
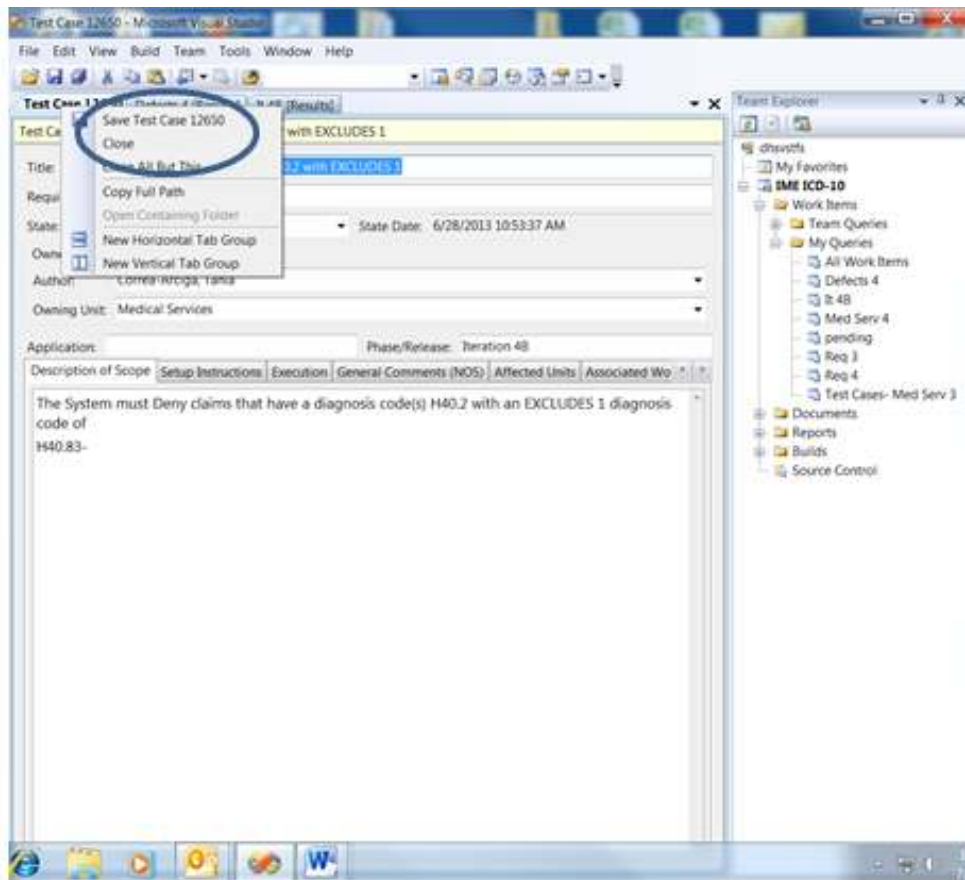
Step 8: If the Test Case fails, document your results under the Actual Results tab and complete *Run by Date*, *Ran By*, and *Outcome*. At the top of the page, right click on the test case number, when the drop down opens, save and close the test case. Please see the Test Defect Process for instructions on how to record the defect.

Forms/Reports:
N/A

RFP References:
MED 10-001-C Amendment 3

Interfaces:
IMAG
MMIS

Attachments: N/A

Updated 06/13/14

MED – ICD-10 Cross Walk Team
Test Defect Process

Purpose: The steps are intended to provide general process guidelines on how to document and report test defects.

Identification of Roles:

<u>Medical Coding Specialist</u> – Maps ICD-9 to ICD-10 codes according to processes. Utilize attention to detail in analyzing, processing, and closing assigned codes/code sets. Seek assistance as needed. Monitor pending codes at least weekly and as appropriate.

<u>Quality Improvement Facilitator</u> (QIF) – Reviews identified aggregate code sets as processed by coders for completeness and accuracy. Monitors escalated and pending codes at least weekly and as appropriate.

Performance Standards:

<u>Medical Coding Specialist</u> – Maintains average personal (Internal Quality Control) IQC score of 95% or greater.

<u>Quality Improvement Facilitator</u> (QIF) – Completes IQC activities for team within assigned timeframes. Utilizes attention to detail in analyzing, processing, and closing escalated codes/code sets. Is a resource to the rest of the team by providing answers to questions necessary to complete assignments.

Path of Business Procedure:

Step1: Refer to the Test Case Execution process for instructions on how to execute the test cases.

Step 2: If the Test Case fails, document your results under the Actual Results tab and complete *Run by Date*, *Ran By*, and *Outcome*. At the top of the page, right click on the test case number, when the drop down opens, save and close the test case. To open a Test Defect for this Test Case, Right Click on this test case number. When the dropdown opens, move your cursor down the list to ADD RELATED WORK ITEM and another dropdown will open. Choose TEST DEFECT.
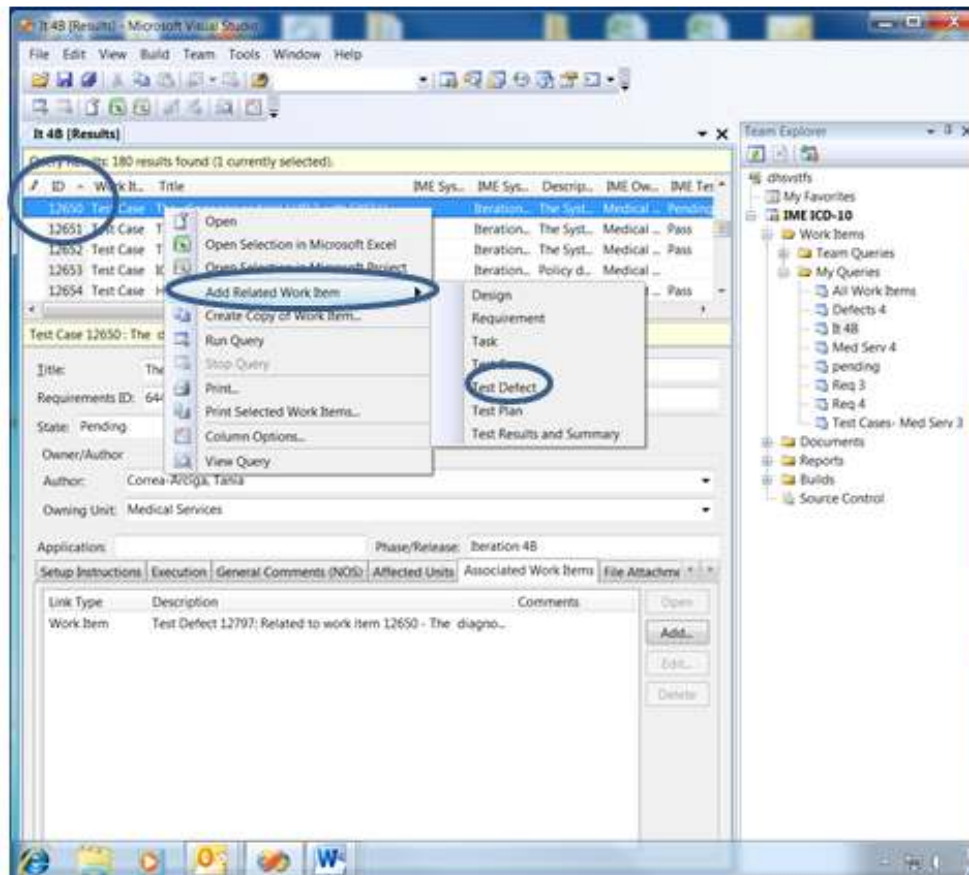
Step 3: A Test Defect will open. Fill out the following Test Defect information.
Type of Defect, System, Phase/Release, Severity, Priority, Assigned To (Test Coordinator) and Owning Unit. On the tab section at the bottom of the Test Defect form, fill out *Description of Defect*, describing what your results were, *Setup Instructions* from the original test case and any information to add under *General Comments*.

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Step 4: The *Associated Work Items* tab will show the test case this defect is connected to. If other test cases have the exact same defect, they can be added to this defect by clicking the ADD button under this tab. At the top of the page, right click on the test defect number, when the drop down opens, save and close the test defect.
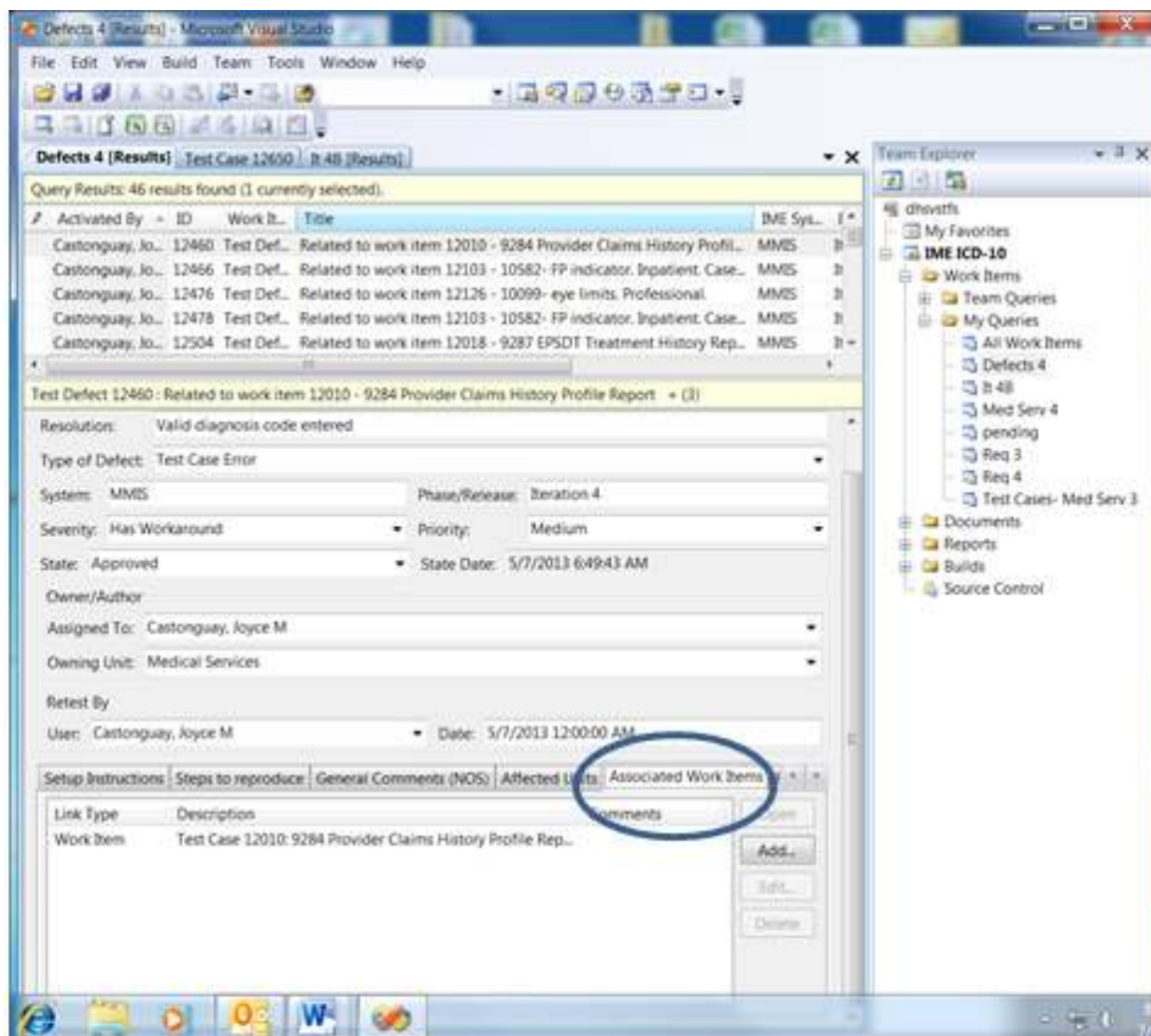
Step 5: Once a Test Defect has been created, you may access the Test Defect information by choosing the Associated Work Items tab in the original Test Case. By double clicking on the Test Defect line you will open the Test Defect.

Updated 06/13/14
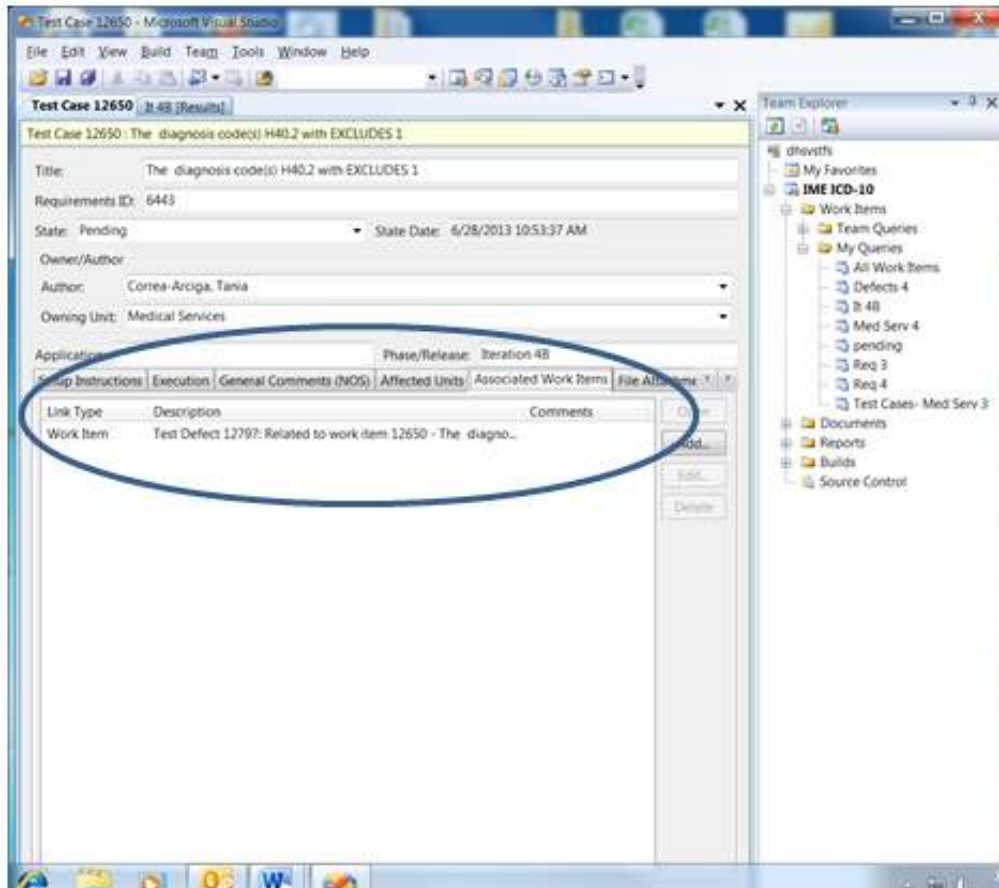
Step 6: The **"Assigned To"** person sends the defect to the workgroup associated with the *Type of Defect* selected.   i.e. Coding Error, Data Error and Environment Error would go to CORE. Requirement Clarification would go to Policy, Test Case Error would go to the Test Case Author and Tester Error back to the person who ran the test case.
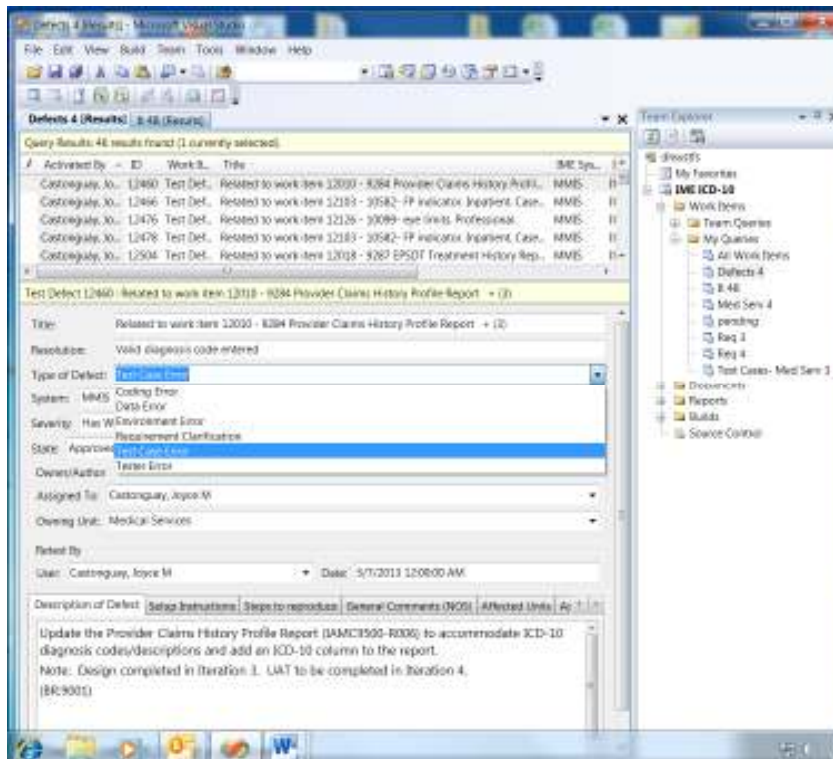
Step 7: Once the defect has been corrected, the "Assigned To" person will reassign the test case to the tester and fill out the Retest By section on the Test Defect.

Updated 06/13/14
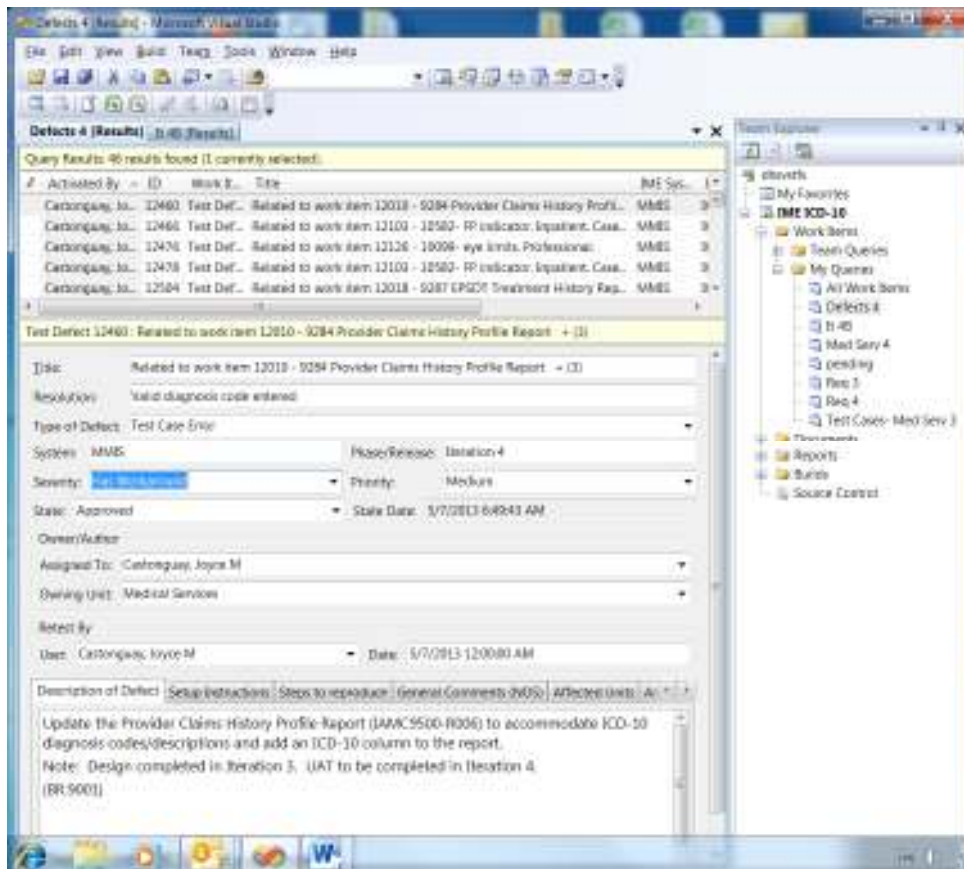
Step 8: The tester will open the test case, rerun the test (if the defect was a Test Case error, these steps will need to be updated with corrected steps).   If the Test Case passes, open the *Actual Results* tab and document "results as expected". Directly above the *Actual Results* tab, fill in *Run by Date*, *Ran By*, and *Outcome*. Save and Close the Test Case.
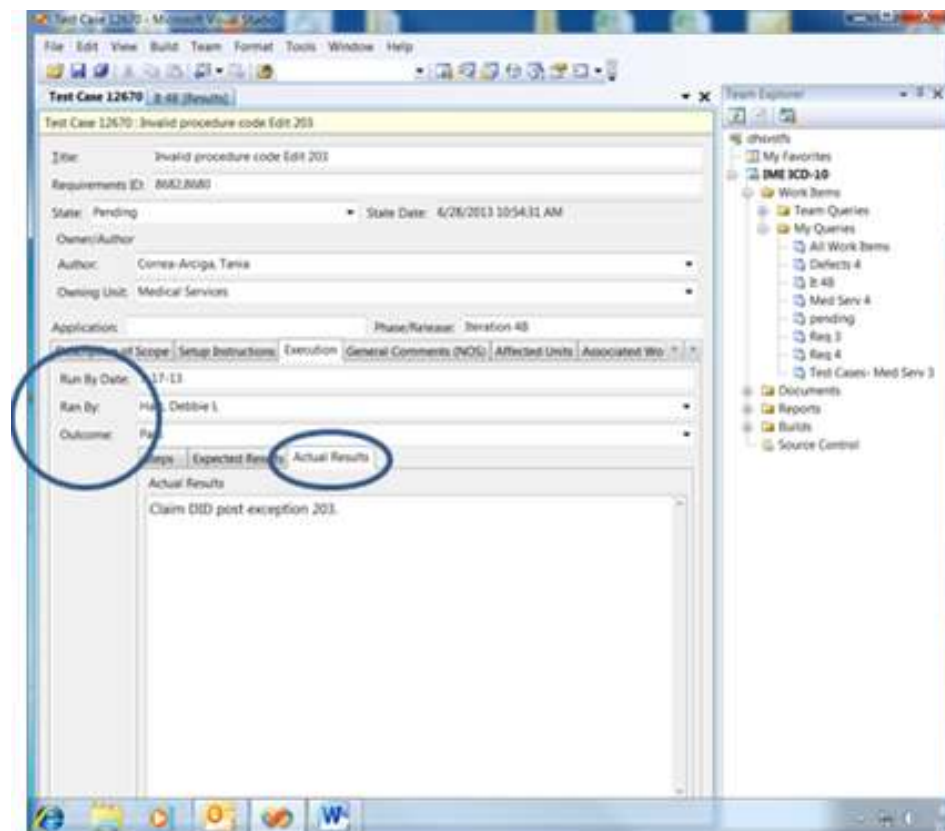
Step 9: Follow the steps below to save a copy of a screen shot of the MMIS claim screen to record the test case results.

To create testing screen shot of claim screen:
1. Press Ctrl/Alt/Print Screen.
2. Open a new Word document.
3. Press Ctrl/V.
4. Save document to your computer, using the test case number as the name.
5. Upload document from your computer to Share point.

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Iowa Department of Human Services
Iowa Medicaid Enterprise (IME)
Medical Services Unit

Step 10: When the test case passes, open the associated defect. Complete the *Resolution*, change *State* to Approved, *Retest Date*, and under the General Comments tab note corrections made to the Test Case.
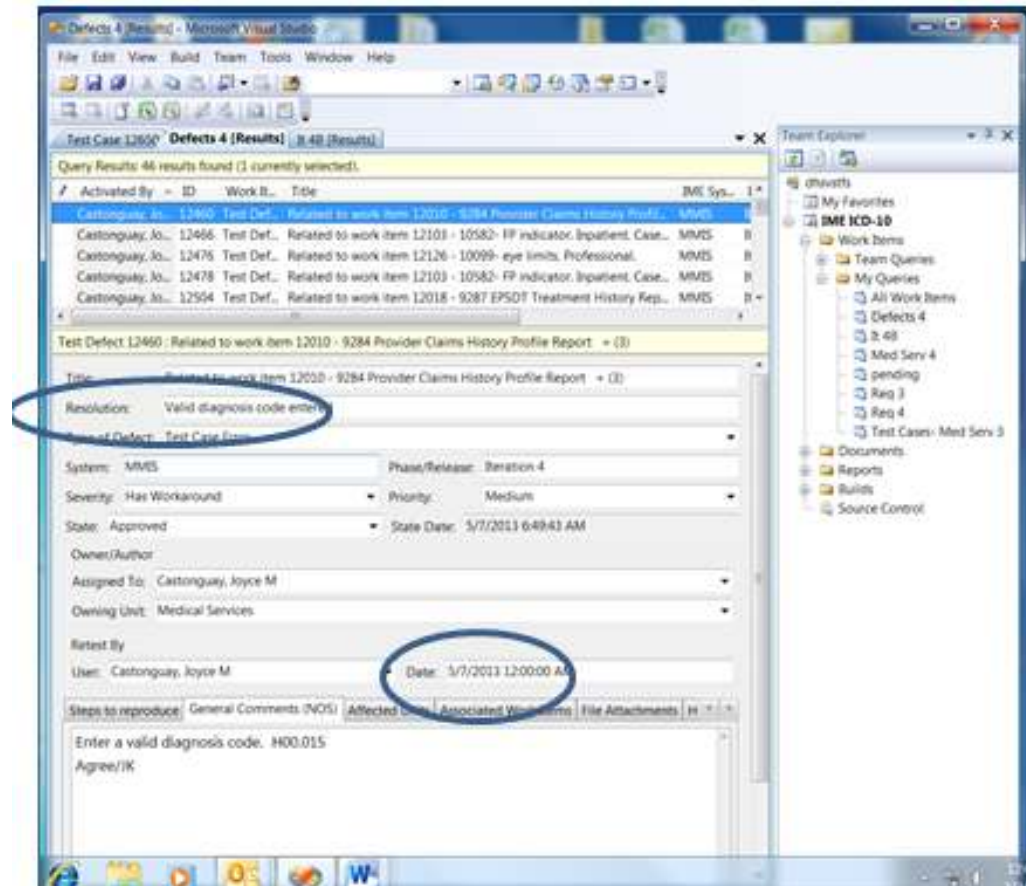
Forms/Reports:
N/A

RFP References:
MED 10-001-C Amendment 3
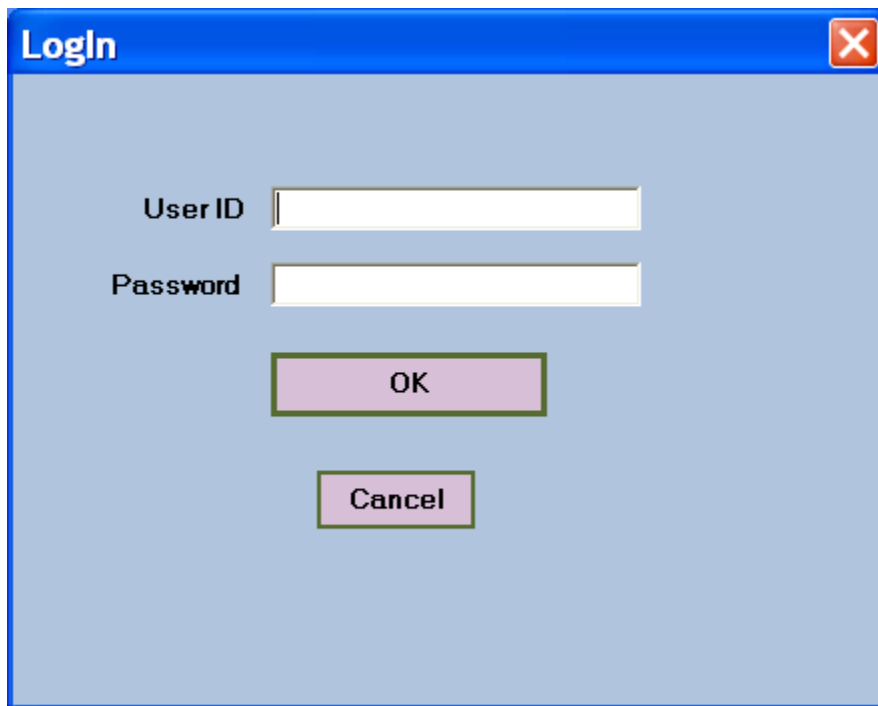
Interfaces:
IMAG
MMIS

Attachments:
N/A

Appendix:

iMAG User Manual for ICD-10 Project Team

This is the Login screen for iMAG. Every user has a User ID and password.
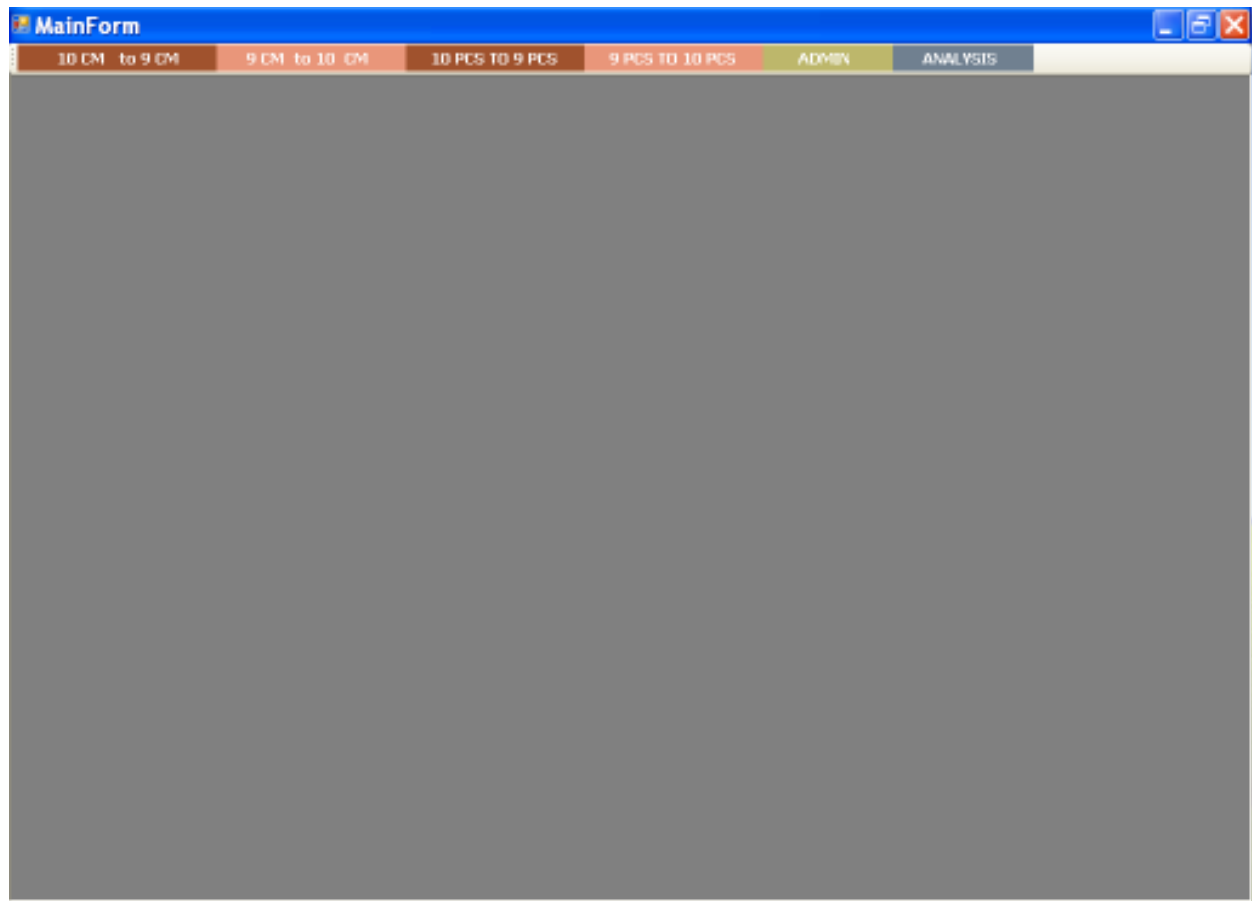
There are 6 tabs on the main screen:

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Chapter 1 ** 10 CM to 9 CM

The ICD10CM to ICD9CM MMIS screen has a drop down box to select the appropriate ICD-10 code. To search for the desired code, the user starts typing the code and then clicks on the code once they find it. Next the user must click on the "Select Code" button.

Iowa Department of Human Services
Iowa Medicaid Enterprise (IME)
Medical Services Unit
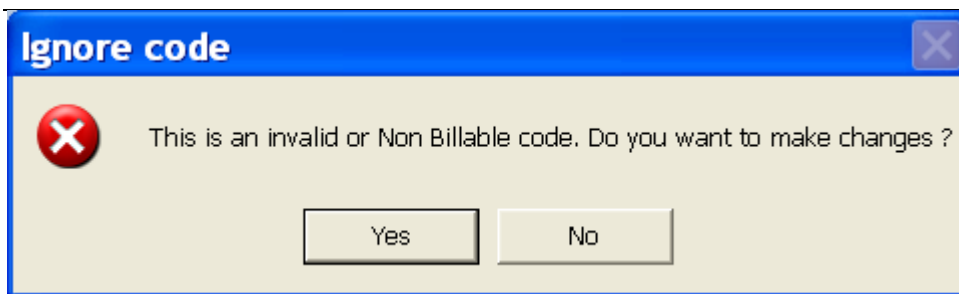
If the user selects an invalid code they will get this error message and have the option of going into the code by clicking on "yes" or returning to the drop down box by clicking on "No".

Once the user selects an ICD-10 code they are able to see the ICD-9 code it crosswalks to and the reference file associated with that code.

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When the user hits edit they are able to select the correct code to crosswalk and enter in the group as well as enter notes, indicators, categories, etc.

If the user tries to complete the code without filling in the required fields (i.e. mapping and indicators) they will get this warning box.

Updated 06/13/14

This is the second page of the ICD-10 to ICD-9 CM tab and it contains the escalate notes information.

If the user goes out of the screen without saving their changes they will get this message.

Updated 06/13/14

If the user hits the pending button on this screen it brings up the "Display Reviews Status" screen which shows all the escalated codes. This can be saved to an Excel spreadsheet if necessary.

Chapter 2 ** 9 CM to 10 CM

Updated 06/13/14
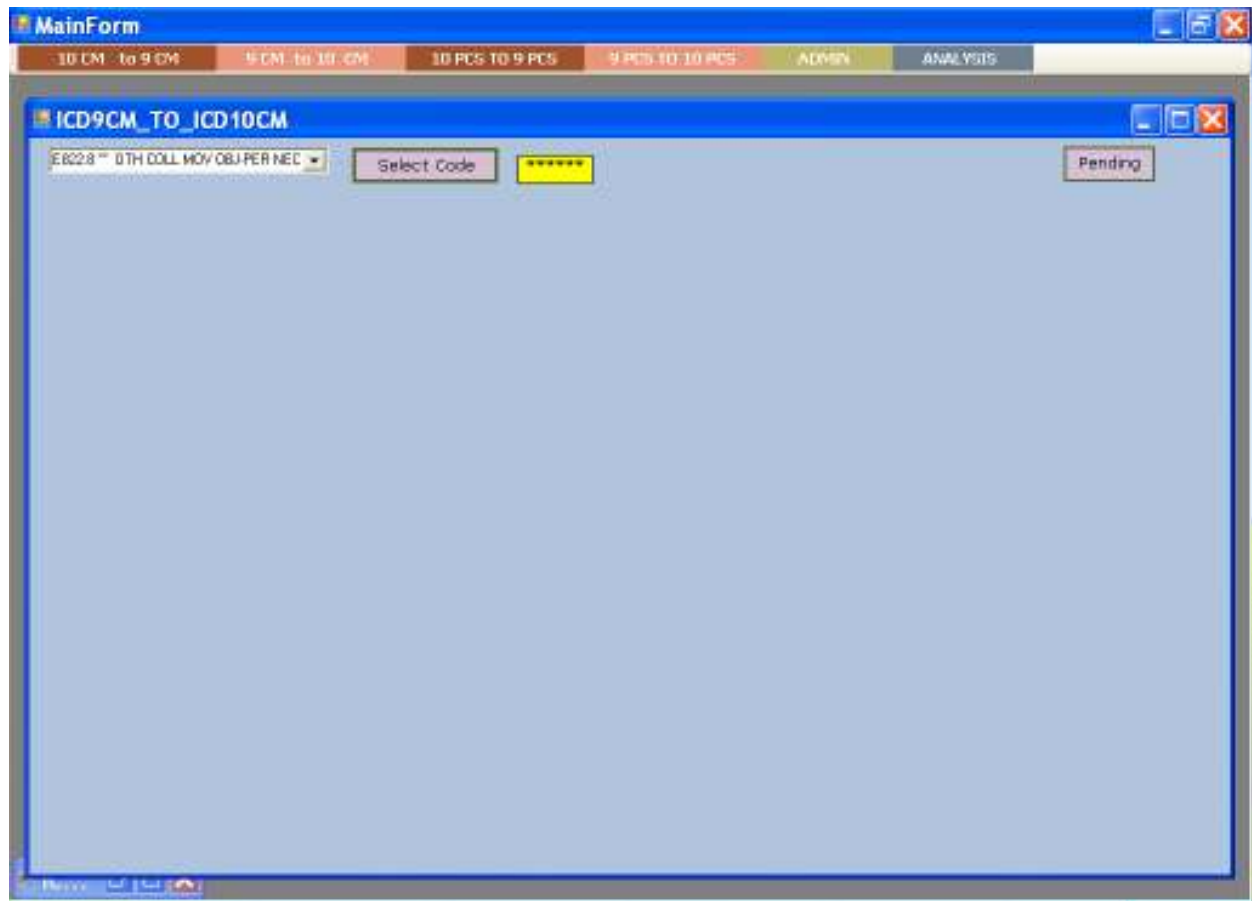
This is what the ICD9CM to ICD10 screen looks like when the user first goes into it. It also has a drop down box to select the codes (see page 3 - 4 for instructions on how to find and select the desired code).

This is the first screen of the ICD-9CM to ICD-10-CM tab.

If the user clicks on the edit button, they can enter the ICD-10 code(s) that cross walk to the ICD-9 code. The user can enter notes, categories, and escalate the code if necessary.

If the user tries to complete the code without filling in the mapping they will get this warning box.

Updated 06/13/14

This is the second page of the ICD-CM to ICD10CM tab where the user is able to enter escalate notes and the escalate resolution.

If the user goes out of the screen without saving their changes they will get this message.

Updated 06/13/14

Display Reviews Status

Program	Status	ICD_CODE	Reviewer	OpenDate	DaysOpen	LastUpdate	DaysLap
9 To 10	Escalated	520.0	jknipp	01/23/2012	176	5/3/2012 10:52 ...	75
9 To 10	Escalated	V02.53	dhart	05/01/2012	77	5/1/2012 2:11 PM	77
9 To 10	Escalated	V02.54	dhart	05/01/2012	77	5/1/2012 2:10 PM	77
9 To 10	Escalated	628.0	jknipp	01/10/2012	189	3/7/2012 1:03 PM	132
9 To 10	Escalated	V25	jknipp	02/15/2012	153	4/10/2012 2:06 ...	98
9 To 10	Escalated	521.30	jknipp	01/23/2012	176	5/3/2012 12:58 ...	75
9 To 10	Escalated	523.40	jknipp	01/24/2012	175	5/3/2012 1:30 PM	75
9 To 10	Escalated	523.5	jknipp	01/24/2012	175	5/3/2012 1:32 PM	75
9 To 10	Escalated	523.6	jknipp	01/24/2012	175	5/3/2012 1:33 PM	75
9 To 10	Escalated	523.8	jknipp	01/24/2012	175	5/3/2012 1:33 PM	75
9 To 10	Escalated	524.00	jknipp	01/24/2012	175	5/3/2012 1:34 PM	75
9 To 10	Escalated	524.10	jknipp	01/24/2012	175	5/3/2012 1:37 PM	75
9 To 10	Escalated	524.60	jknipp	01/24/2012	175	5/3/2012 1:47 PM	75
9 To 10	Escalated	524.70	jknipp	01/24/2012	175	5/3/2012 1:50 PM	75
9 To 10	Escalated	524.81	jknipp	01/24/2012	175	5/3/2012 1:53 PM	75
9 To 10	Escalated	525.60	jknipp	01/24/2012	175	5/3/2012 2:07 PM	75
9 To 10	Escalated	525.71	jknipp	01/24/2012	175	5/3/2012 2:10 PM	75
9 To 10	Escalated	724.8	aflening	01/03/2012	196	7/10/2012 1:20 ...	7
9 To 10	Escalated	752.40	jknipp	01/27/2012	172	4/17/2012 11:14..	91
9 To 10	Escalated	752.49	jknipp	01/27/2012	172	4/16/2012 11:17..	92
9 To 10	Escalated	905.0	nhanson	07/12/2012	5	7/12/2012 10:33..	5
9 To 10	Escalated	522.0	jknipp	01/23/2012	176	5/3/2012 1:22 PM	75
9 To 10	Escalated	523.00	jknipp	01/24/2012	175	5/3/2012 1:25 PM	75

OK   Save To XL

If the user hits the pending button on this screen they bring up the "Display Reviews Status" screen which shows all the escalated codes. This can be saved to an Excel spreadsheet if necessary.

Chapter 3 ** 10 PCS to 9 PCS

Updated 06/13/14

This is the initial screen in the ICD10PCS to ICD9 PCS. The biggest difference between the diagnosis screens and procedure screens is there is no drop down box to search for the codes. A drop down box is potentially going to be added to the procedure screens in a future upgrade to the program.

When the user hits the "select proc code" button this is the screen that comes up.

To search for an ICD-10 PCS code, the user must enter either the first 3 digits in the code or…

SearchICDCodes

Search ICD 10PCS Codes   ○ Begins   ● Part Of The Desc

gall

0F140D3 **	Bypass Gallbladder to Duoden w Intralum Dev, Open
0F140D4 **	Bypass Gallbladder to Stomach w Intralum Dev, Ope
0F140D5 **	Bypass Gallbladder to R Hep Duc w Intralum Dev, Op
0F140D6 **	Bypass Gallbladder to L Hep Duc w Intralum Dev, Op
0F140D7 **	Bypass Gallbladder to Caud Duct w Intralum Dev, Op
0F140D8 **	Bypass Gallbladder to Cyst Duct w Intralum Dev, Op
0F140D9 **	Bypass Gallbladder to CBD with Intralum Dev, Open
0F140DB **	Bypass Gallbladder to Sm Int w Intralum Dev, Open
0F140Z3 **	Bypass Gallbladder to Duodenum, Open Approach
0F140Z4 **	Bypass Gallbladder to Stomach, Open Approach
0F140Z5 **	Bypass Gallbladder to Right Hepatic Duct, Open Appr
0F140Z6 **	Bypass Gallbladder to Left Hepatic Duct, Open Apprc
0F140Z7 **	Bypass Gallbladder to Caudate Hepatic Duct, Open A
0F140Z8 **	Bypass Gallbladder to Cystic Duct, Open Approach
0F140Z9 **	Bypass Gallbladder to Common Bile Duct, Open Appr
0F140ZB **	Bypass Gallbladder to Small Intestine, Open Approac
0F144D3 **	Bypass Gallbladder to Duoden w Intralum Dev, Perc
0F144D4 **	Bypass Gallbladder to Stomach w Intralum Dev, Perc
0F144D5 **	Bypass Gallbladder to R Hep Duc w Intralum Dev, Pe
0F144D6 **	Bypass Gallbladder to L Hep Duc w Intralum Dev, Pe
0F144D7 **	Bypass Gallbladder to Caud Duct w Intralum Dev, Pe
0F144D8 **	Bypass Gallbladder to Cyst Duct w Intralum Dev, Per
0F144D9 **	Bypass Gallbladder to CBD w Intralum Dev, Perc Enc
0F144DB **	Bypass Gallbladder to Sm Int w Intralum Dev, Perc E

SELECTED   CODES

SELECT CODE/S

CANCEL   Save This Search List

Clear Item

Save Selected Codes TO XL

..the first 3 letters in the description of the code.

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After the user finds the ICD-10 PCS code they are looking for, they have to double click on the code and it will populate in the "selected codes' box. Next the user must hit the select code button.

The list of codes generated from the search can be saved to an Excel spreadsheet if necessary.

Updated 06/13/14

Once an ICD-10-PCS code is selected this is the first screen that comes up.

Updated 06/13/14

When the user hits edit this enables them to enter correct ICD-9 procedure code(s) that cross walk to this ICD-10-PCS code and enter them as a group. They are also able to attach categories, escalate the code and enter notes if necessary from this screen.
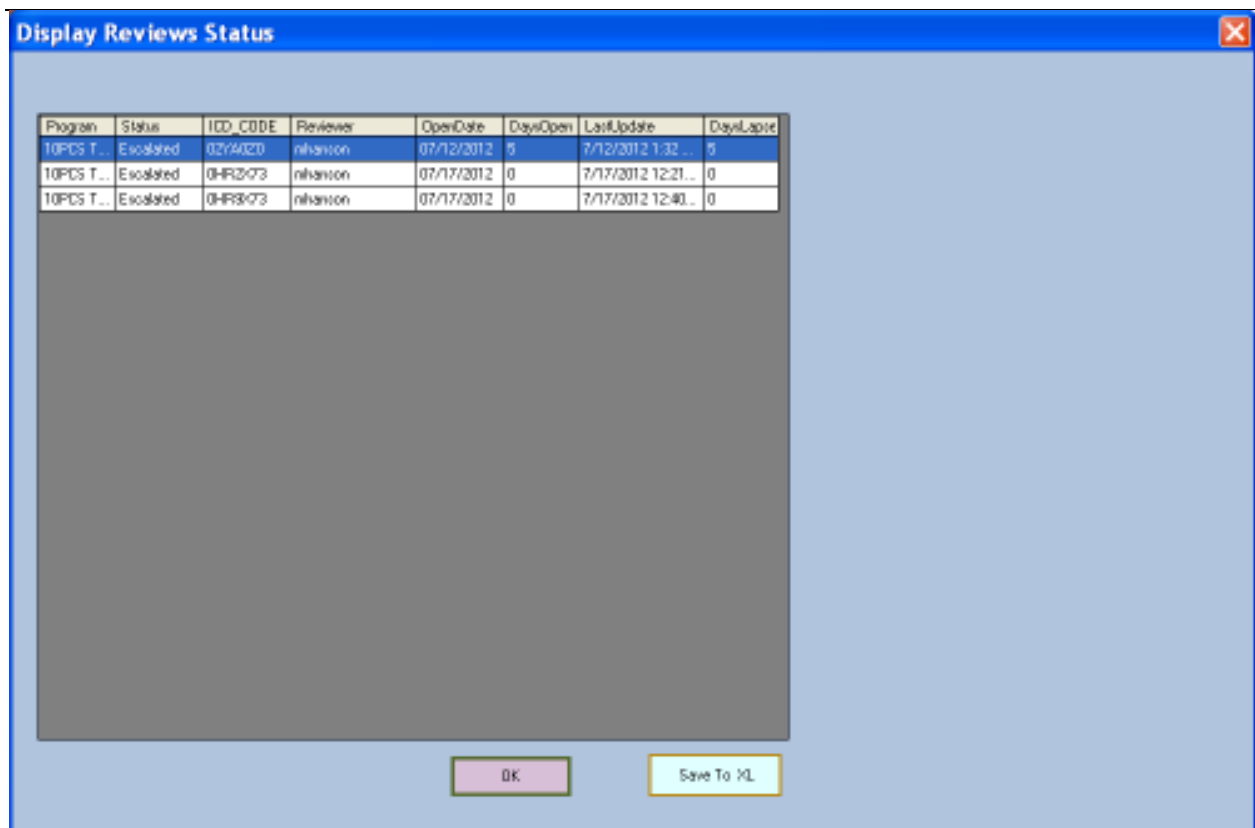
If the user tries to complete the code without filling in the required fields (i.e. indicators or mapping, they will get one of the above error messages.

Updated 06/13/14

This is the second page of the ICD-10-PCS to ICD-9 screen. This is where the user enters Escalate notes and the resolution.

If the user goes out of the screen without saving their changes they will get this message.

Display Reviews Status

Program	Status	ICD_CODE	Reviewer	OpenDate	DaysOpen	LastUpdate	DaysLapse
10PCS T...	Escalated	0ZY40Z0	nihanson	07/12/2012	5	7/12/2012 1:32 ...	5
10PCS T...	Escalated	0HRZX73	nihanson	07/17/2012	0	7/17/2012 12:21...	0
10PCS T...	Escalated	0HR8X73	nihanson	07/17/2012	0	7/17/2012 12:40...	0

OK   Save To XL

If the user hits the pending button on this screen you will bring up the "Display Reviews Status" screen which shows all the escalated codes. This can be saved to an excel spreadsheet if necessary.

Chapter 4 ** ICD-9 to ICD-10-PCS tab

Updated 06/13/14

This is the first screen when the user goes into the ICD9 to ICD-10-PCS tab.

When the user hits the "select proc code" button this is the screen that comes up.

Updated 06/13/14

SearchICDCodes

Search ICD 9PCS Codes   ⦿ Begins   ○ Part Of The Desc

034

034 ** EXCISION OR DESTRUCTION OF LESION OF SPI

SELECTED   CODES

SELECT CODE/S

CANCEL   Save This Search List

Clear Item

Save Selected Codes TO XL

To search for an ICD-10 PCS code, the user must enter either the first 3 digits in the code or…

Updated 06/13/14

SearchICDCodes

Search ICD 9PCS Codes   ○ Begins   ● Part Of The Desc
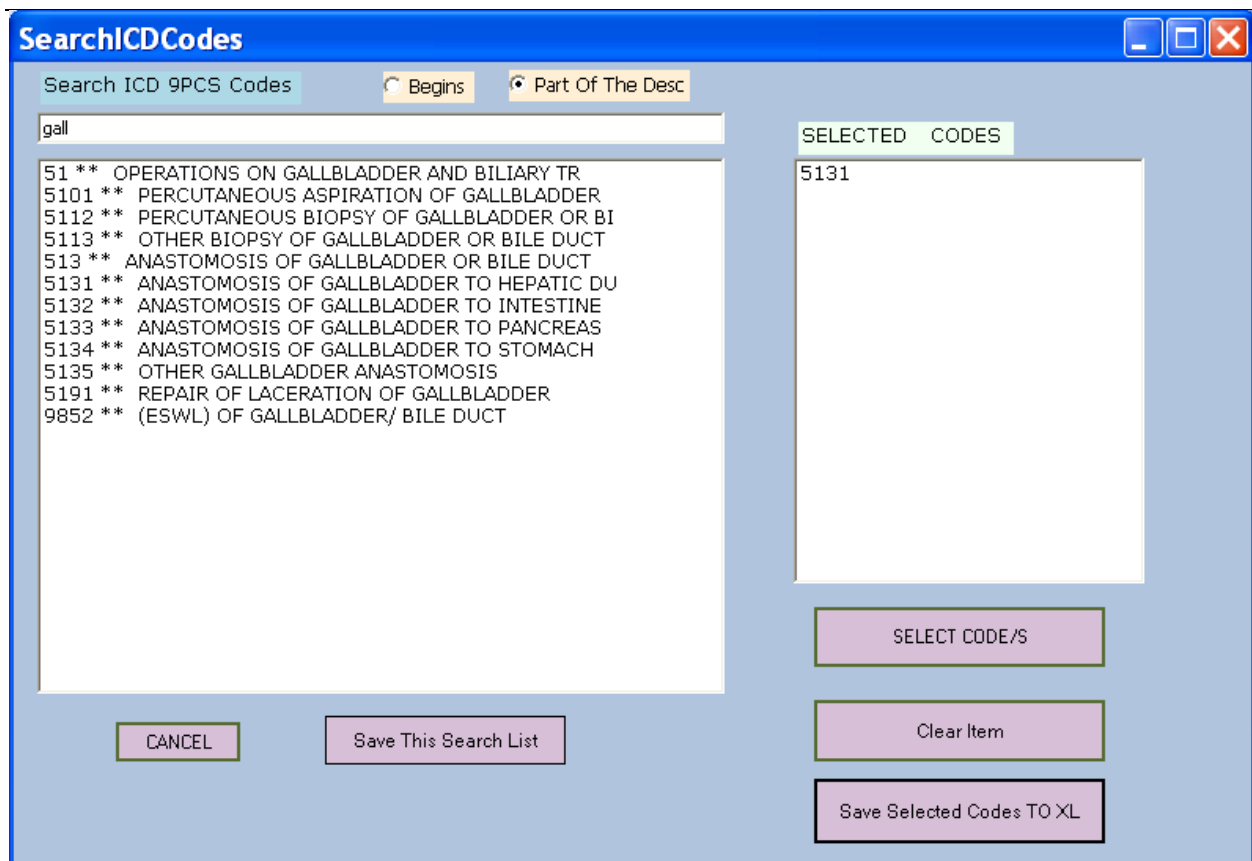
gall

```
51 **  OPERATIONS ON GALLBLADDER AND BILIARY TR
5101 **  PERCUTANEOUS ASPIRATION OF GALLBLADDER
5112 **  PERCUTANEOUS BIOPSY OF GALLBLADDER OR BI
5113 **  OTHER BIOPSY OF GALLBLADDER OR BILE DUCT
513 **  ANASTOMOSIS OF GALLBLADDER OR BILE DUCT
5131 **  ANASTOMOSIS OF GALLBLADDER TO HEPATIC DU
5132 **  ANASTOMOSIS OF GALLBLADDER TO INTESTINE
5133 **  ANASTOMOSIS OF GALLBLADDER TO PANCREAS
5134 **  ANASTOMOSIS OF GALLBLADDER TO STOMACH
5135 **  OTHER GALLBLADDER ANASTOMOSIS
5191 **  REPAIR OF LACERATION OF GALLBLADDER
9852 **  (ESWL) OF GALLBLADDER/ BILE DUCT
```

SELECTED   CODES

SELECT CODE/S

Clear Item

Save Selected Codes TO XL

CANCEL   Save This Search List

…the first 3 letters in the description of the code.

.

After the user finds the ICD-9 procedure code they are looking for, they have to double click on the code and it will populate in the "selected codes' box. Next the user must hit the select code button.

The list of codes generated from the search can be saved to an Excel spreadsheet if necessary.

Updated 06/13/14

Once an ICD-9 procedure code is selected this is the first screen that comes up.

Updated 06/13/14

When the user hits edit this enables them to enter correct ICD-9 procedure code(s) that cross walk to this ICD-10-PCS code and enter them as a group. They are also able to attach categories, escalate the code and enter notes if necessary from this screen.
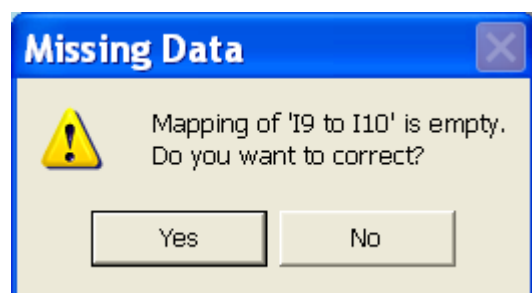
If the user tries to complete the code without filling out the mapping they will get this error message.

Updated 06/13/14

This is the second page of the ICD-10-PCS to ICD-9 screen. This is where the user enters Escalate notes and the resolution.

If the user goes out of the screen without saving their changes they will get this message.

Chapter 5 ** Admin

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The coder screen is the first screen that the user will go into after clicking on the Admin tab.

The user identifies which code type (ICD10 diagnosis, ICD9 diagnosis, etc) first and then they will have to enter the first 3 digits of the code set they wish to find out the status of.   Next the user must click on the "Identify Code Status" button.

Next, the "Display Table Data" will pop up. This table will have all the codes identified in the range selected and the status (completed, pending, awaiting rule, etc). If the code has not been opened yet there will be five X's in the status box.

Updated 06/13/14

The "Coder" screen also contains the "Replicate codes" function. First the user must select the code type and then enter the original or base code that they wish to replicate. Then they must click on the "Select Code to Replicate" button.

This brings up the "Search" box. See pages 14-17 for the instructions on how to search these codes. The user may select as many codes as needed to be replicated. The "Search List" and "Selected Codes" list can be saved to an Excel spreadsheet if desired.

The next screen on the Admin tab is the "Manager" screen.

To get the Performance Report, the user enters the correct from and to dates and then clicks on the "Get Reviewers Performance" button.

To get a list of all of the pending codes the user must first click on the code type (i.e. ICD10 diagnosis, ICD9 diagnosis, etc) and then click on the "Pending Review Details" button.

This brings up a "Display Review Status" table that lists all the pending codes by reviewer. This can be saved to an Excel spreadsheet if necessary.

To get the total number of pending codes by code type the user must first click on the desired code type and then click on the "Total Pending" button.

To get the total number of completed codes by code type the user must first click on the desired code type and then click on the "Total Completed" button.

To unlock codes the user must first click on the code type and then enter the code number that needs to be unlocked and then click on the "Unlock Code" button.

The above message will appear once the code has been unlocked.

Updated 06/13/14

This screen is also where a new user can be added to iMAG or a user's account can be updated or deleted. Only certain users (i.e. managers) have the authority to make these changes.

Updated 06/13/14

The three remaining buttons on this screen have restricted administrative rights. They are the "Export ICD10 CM", the "Code Category" and the "IQA codes" buttons. These buttons perform the following functions:

Export ICD10 CM – Pressing this button exports a report of all current data from IMAG in a format that is ready for upload directly into MMIS.

Code Category – Pressing this button exports a report of current IMAG categories and associated codes.

IQA codes –Pressing this button exports a specified number of randomly selected completed codes from IMAG for each coder, to be reviewed for IQC (Internal Quality Control) purposes.

The last screen on the Admin tab is "Sys Admin Only". This screen contains reference files and is only used by the programmer

Chapter 6 ** Analysis/Codes Association
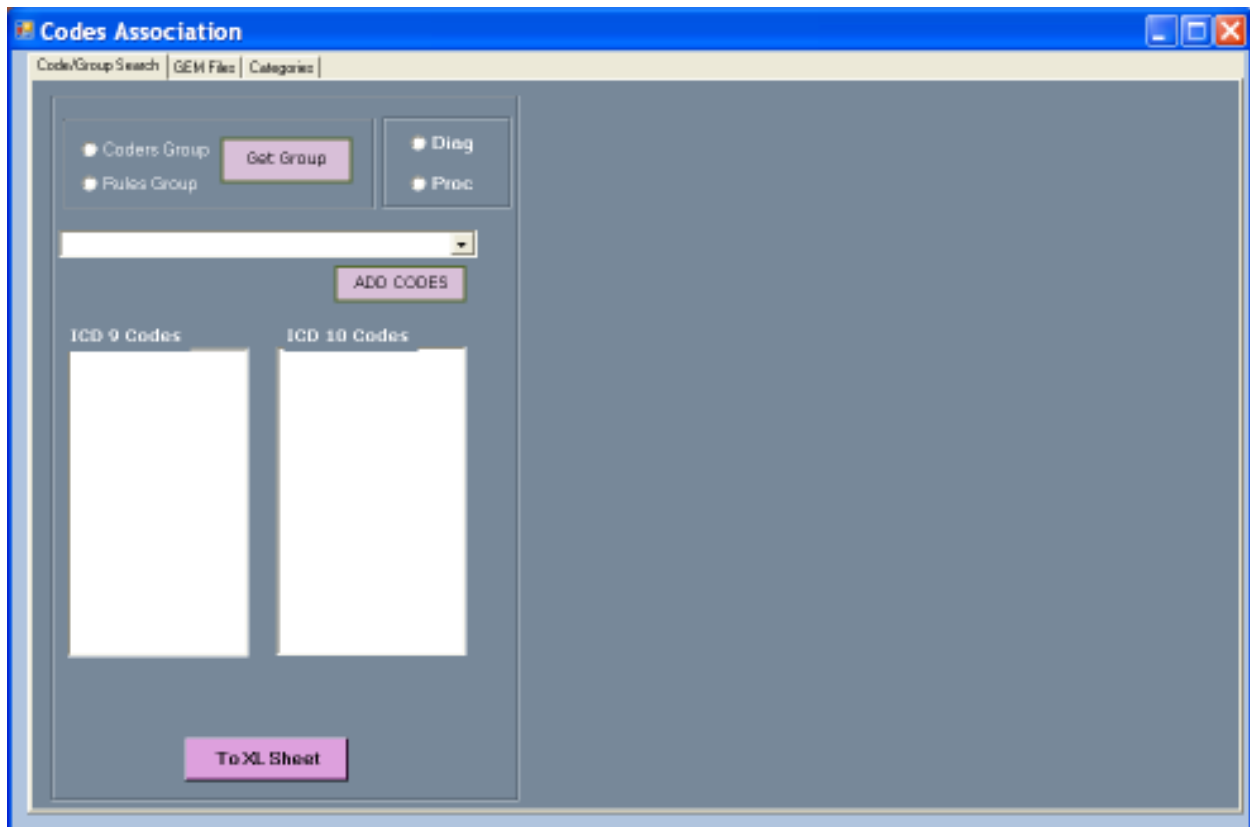
The first screen on the Analysis tab is called "Code/Group Search". This is where coders can add codes to a coders group and Quality Improvement Facilitators can add codes to a rules group.
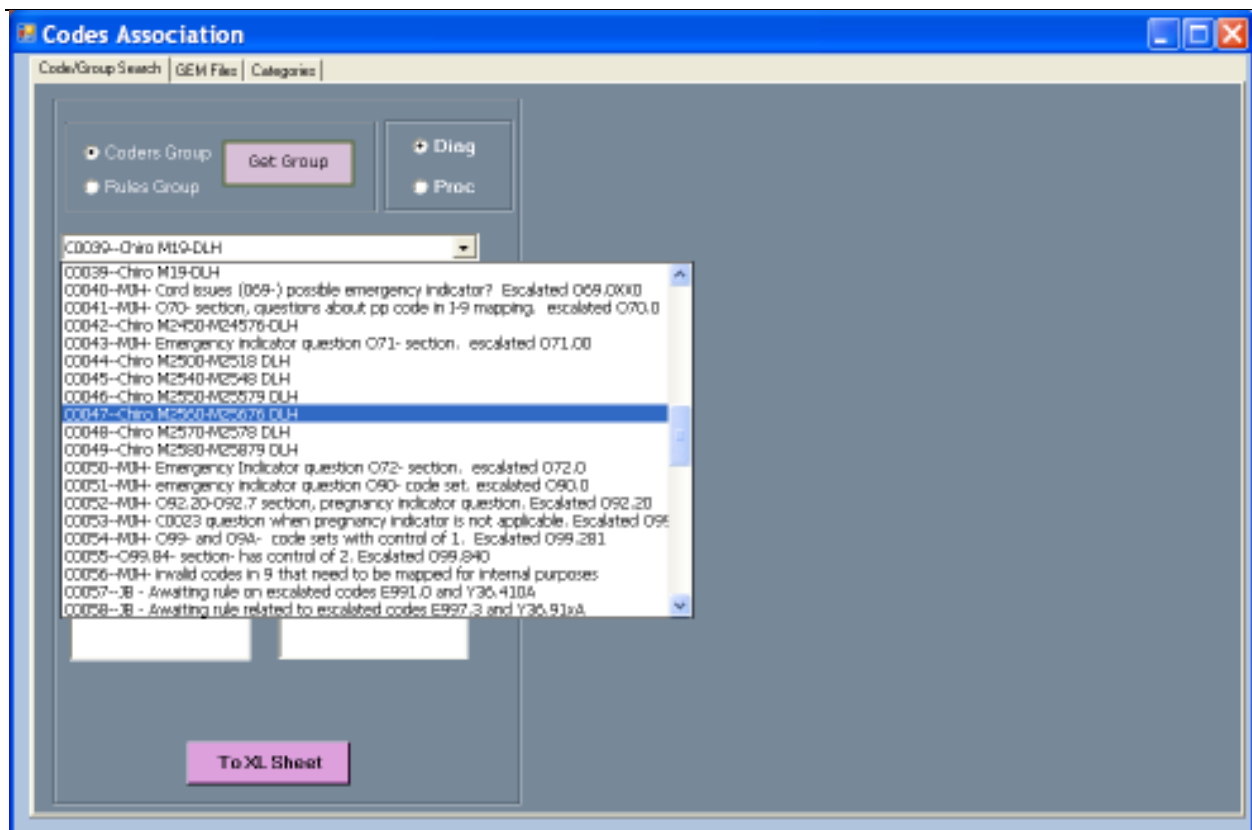
The user must first click on the type of group desired (i.e. coders group vs. rules group) and the type of code (i.e. diagnosis vs. procedure). Then the user selects the correct coders group or rules group from the drop down box.

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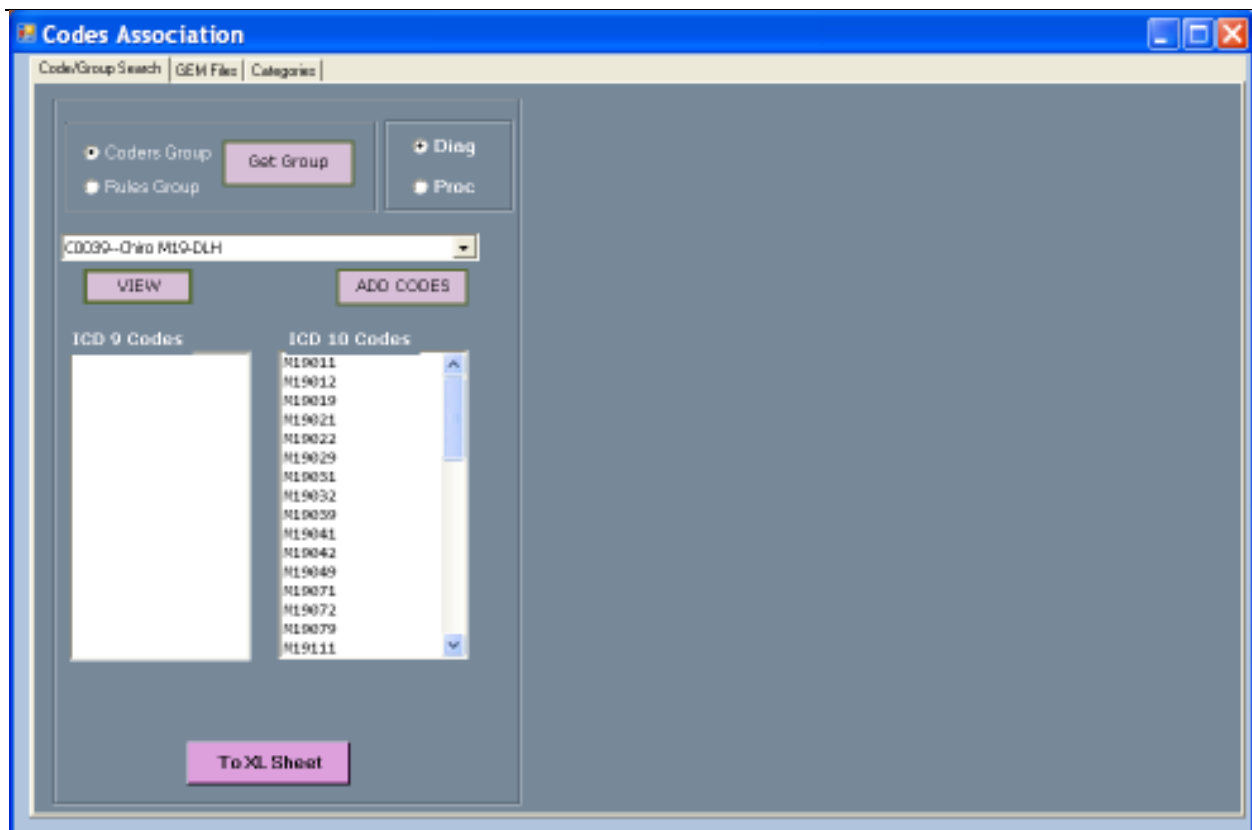
After the user selects the correct group and clicks on the "View" button the codes that had previously been assigned to the group will appear.
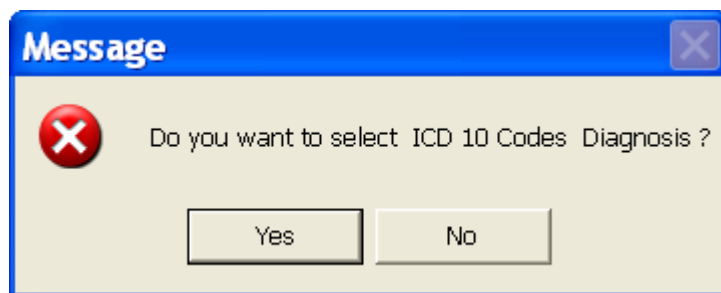
If the user wishes to enter additional codes to the group they need to click on the "Add codes" button and the above message box will appear.

Updated 06/13/14

If the user clicks on yes on the message box on the previous page the "Search ICD Codes box appears. See pages 14-17 for the instructions on how to search these codes. The user may select as many codes as necessary to be added to the group. The "Search List" and "Selected Codes" list can be saved to an Excel spreadsheet if desired.

After the user is finished selecting the ICD-10 codes, they will get this box and the same process is repeated to select the ICD-9 codes for the group.

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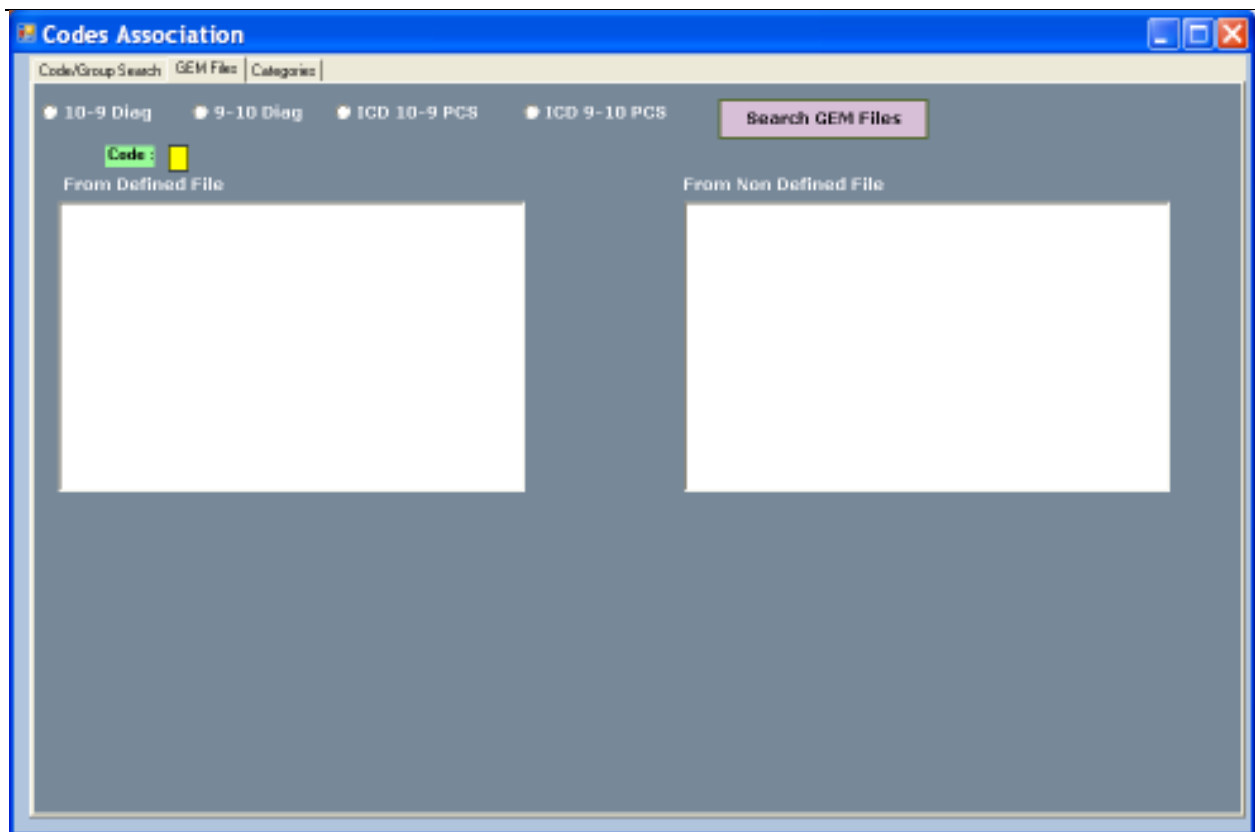
The next screen on the Analysis/Codes Association tab is the "GEM Files". The user must select the code type and then hit the "Search Gem Files" button.

See pages 14-17 for the instructions on how to search these codes. The "Search List" and "Selected Codes" list can be saved to an Excel spreadsheet if desired.

Updated 06/13/14

Once the user selects the source code the target codes populate in the defined file and non-defined file boxes.
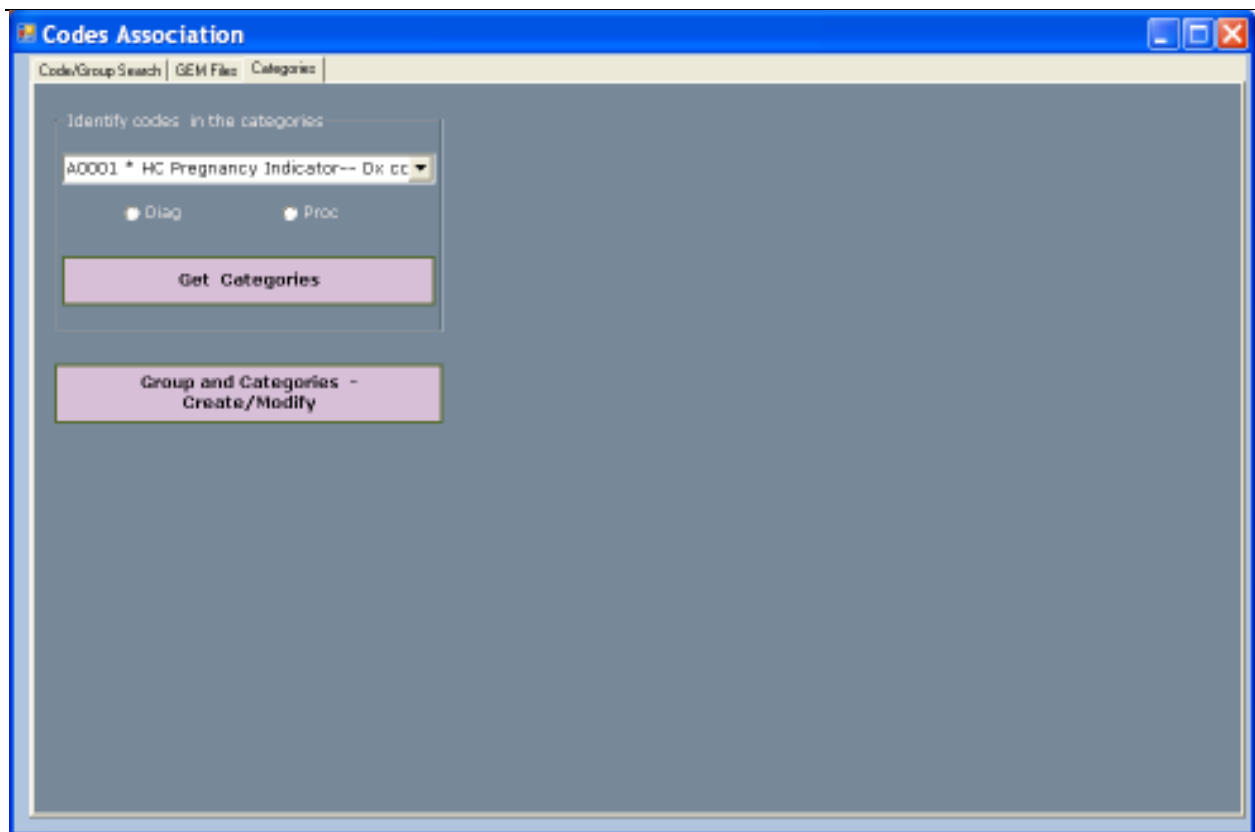
The last screen on the Analysis/Codes Association tab is "Categories". This screen is where the user can obtain the codes that have been linked to a category. The user selects the category they wish to see and clicks on the "Get Categories" button.

This brings up the "Display Table Data" list that shows all the codes attached to the category. This list can be copied and pasted into an Excel spreadsheet if necessary.
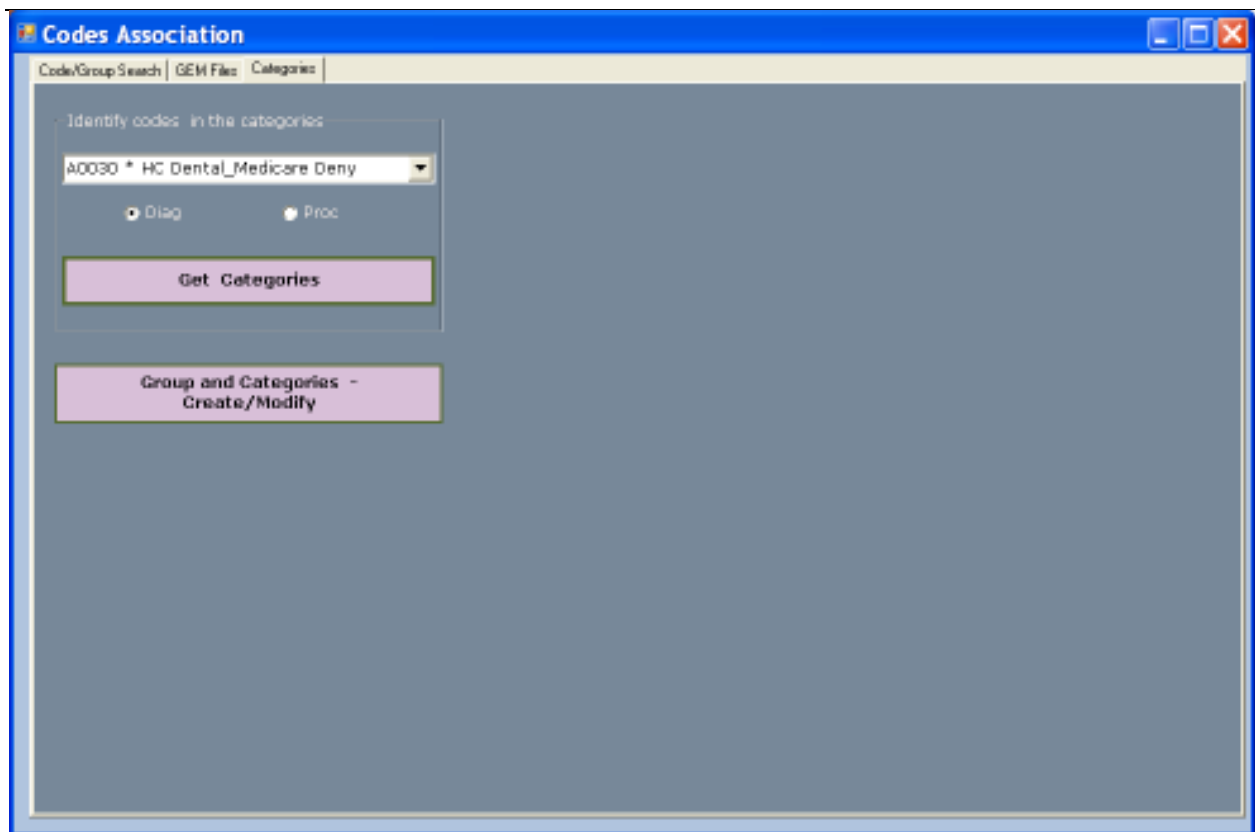
The user clicks on the "Group and Categories – Create/Modify" button on the Analysis/Codes Association screen to create and/or edit coders groups, categories, and rules groups.

This is the screen that pops up after the user clicks on the "Group and Categories – Create/Modify" button. The user selects the type of group they want to create and/or edit and clicks on the appropriate button (i.e. "create new group" or "edit or view" button).

This box pops up if the create new group button is selected. The user enters a short description of the group and then clicks on the "Save" button.

This is the box that pops up in the edit or view button is selected. The user chooses the correct group they wish to edit or view and then can make changes if desired. After the changes are made the user clicks on the "Save" button.

A category can be deleted by checking the "Delete Group" box and then clicking on the "Save" button.